

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12444 12131

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eldersburg		c. LENGTH OF STAY IN lb 23 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O. Sykesville		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS Eldersburg	
3. NAME OF DECEASED (Type or print) MYRTIE		First ADELSPERGER	Middle
4. DATE OF DEATH November 15, 1961		5. DATE Month 15 Day Year 1961	6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
7. SEX Female		8. COLOR OR RACE White	9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital attendant		10b. KIND OF BUSINESS OR INDUSTRY State Hospital	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Columbus A. Conaway		14. MOTHER'S MAIDEN NAME Ida B. Pickett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	17. INFORMANT Mr. Ross C. Hornbaker, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENO-CARCINOMA SIGMOID COLON		19. INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) METASTATIC CARCINOMA OF LUNGS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1935 to 1961, that (I) (we) last saw the deceased alive on 11/15 1961, and that death occurred at 6:20 PM from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>W. H. Lawson, Jr., M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.		22d. ADDRESS RFD #2 Sykesville, Maryland	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 11-18, 1961	23c. NAME OF CEMETERY OR CREMATORIAL Winfield Church of God
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
		25a. REC'D BY REGISTRAR Arthur S. Kline	25b. REGISTRAR'S SIGNATURE
		DATE NOV 20 '61	

NO. 10
death.

3 hours after
filled in the funeral.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12445

CERTIFICATE OF DEATH

12432

1. PLACE OF DEATH
a. COUNTY

Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Westminster

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Carroll County General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

William Russell

M.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED X

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

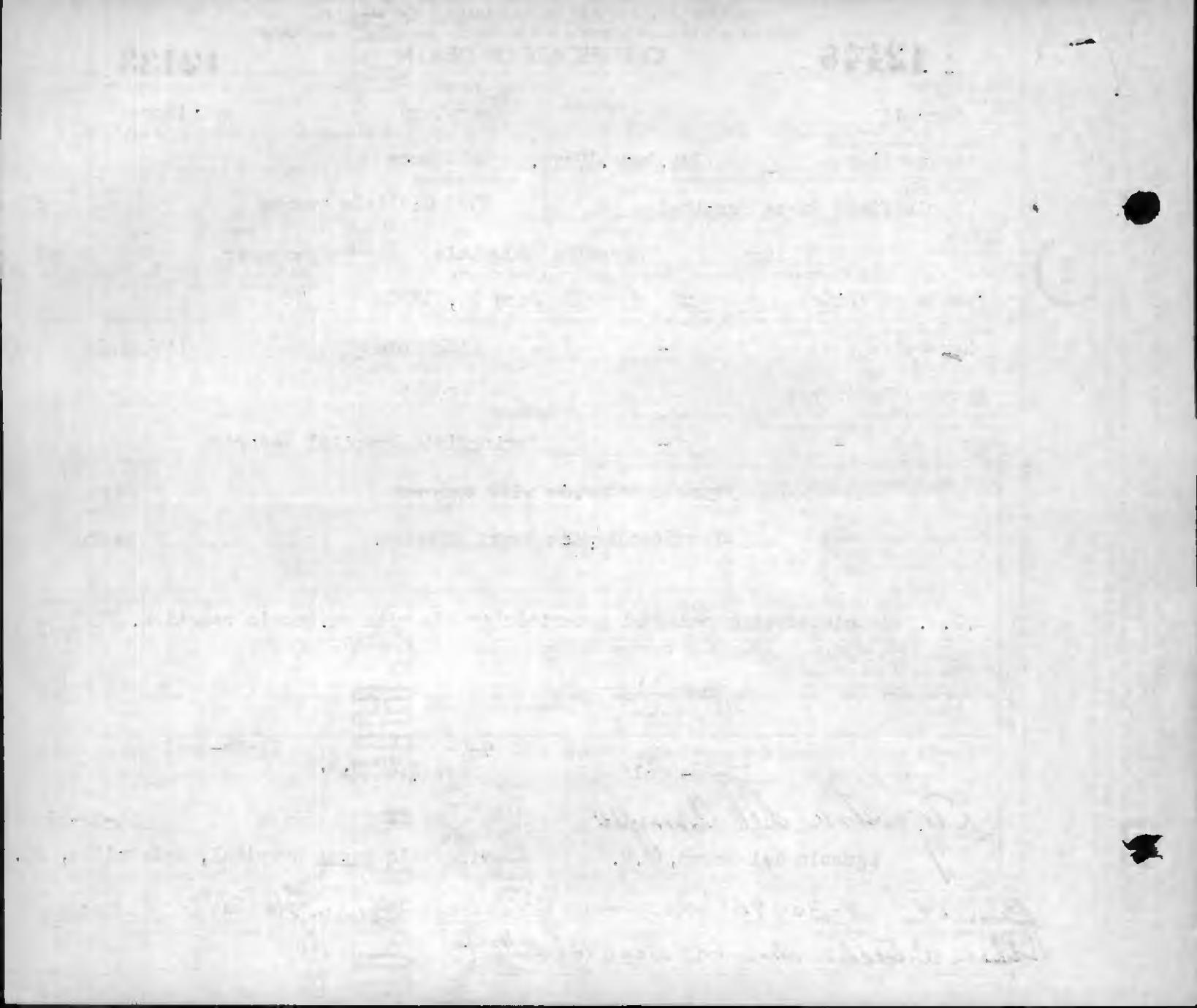
CERTIFICATE OF DEATH

12446

12433

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1yr. 2mos. 17dys.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna		First Marcella	Middle Augaitis
4. DATE OF DEATH November 26		Month 1961	Day 19
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1886	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME Matthew Dubinskas		14. MOTHER'S MAIDEN NAME Eva ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia with empyema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease. DUE TO (c) —			
INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	
20f. (City or town) — (County) — (State) —		21. I certify that (I) (this hospital) attended the deceased from 9-9-1960 to 11-26-1961 , that (I) (we) last saw the deceased alive on 11-26-1961 , and that death occurred at 4:40 p.m. from the causes and on the date stated above.	
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 11-26-61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-30-1961	
23c. NAME OF CEMETERY OR CREMATORIAL Most Holy Redeemer Cemetery		23d. LOCATION (City, town, or county) Baltimore (State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE Charles W. Farkushan		25a. ADDRESS 637 Wards Blvd. Baltimore MD	
25b. REC'D BY REGISTRAR DEC 1 '61		25c. REGISTRAR'S SIGNATURE Arthur S. Kraus	



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FOR STATE
HEALTH DEPT.

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4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12447

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12434

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Westminister

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First MIDDLE Last

VERNON L. BAKER

5. SEX

6. COLOR OR RACE

Male White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Clerk

10c. BIRTHPLACE (State or foreign country)

Md.

11. CITIZEN OF WHAT COUNTRY?

U. S. A.

12. ADDRESS

Mr. Nellie Zimmerman - Sykesville, Md.

13. FATHER'S NAME

William Baker

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

yes. W.W.II 1942-43

16. SOCIAL SECURITY NO.

212-03-4620

17. INFORMANT

Mr. Nellie Zimmerman - Sykesville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

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Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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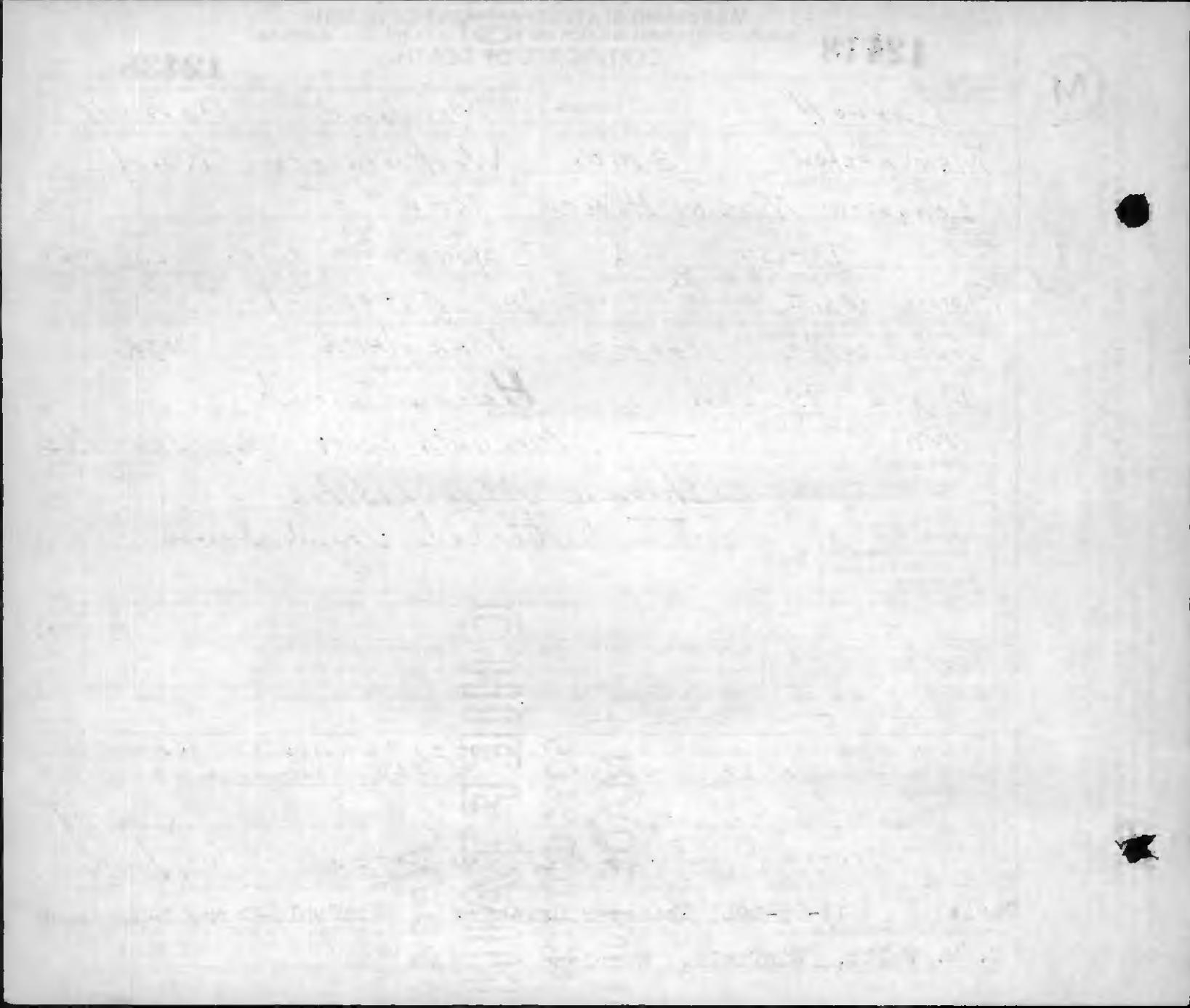
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12448 12435

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN 1b <i>3 MO.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster Rural</i>				
3. NAME OF DECEASED (Type or print) <i>DAISY</i>		First <i>A.</i>	Middle <i>BARNES</i>			
4. DATE OF DEATH <i>NOV. 23 1961</i>		Month <i>NOV.</i>	Day <i>23</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>JAN 25 1880</i>		9. AGE (in years last birthday) <i>81</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>81</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>house</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>DAVID B. BLOOM</i>				
14. MOTHER'S MAIDEN NAME <i>Helena Barber</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs Ruth Ecker</i>	Address <i>Hagerstown Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Chronic Myocarditis</i>		DUE TO <i>Arteriosclerotic Cardiovascular Disease</i>				
DUE TO <i>—</i>		DUE TO <i>—</i>				
(c) DUE TO <i>—</i>		DUE TO <i>—</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>—</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> 19 p. m. <i>—</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that (I) (this hospital) attended the deceased from <i>August 24 1961</i> to <i>NOV 23 1961</i> , that (I) (we) last saw the deceased alive on <i>11-21 1961</i> and that death occurred at <i>5:45 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>11-23-61</i>				
22a. SIGNATURE <i>Joseph E. Bush</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <i>—</i>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11-23-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>		22d. ADDRESS <i>Hampstead Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-25-1961</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Ebenezer Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Winfield-Carroll-Maryland</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Waltz, Winfield, Maryland</i>		25a. REC'D BY REGISTRAR DATE NOV 27 '61				
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

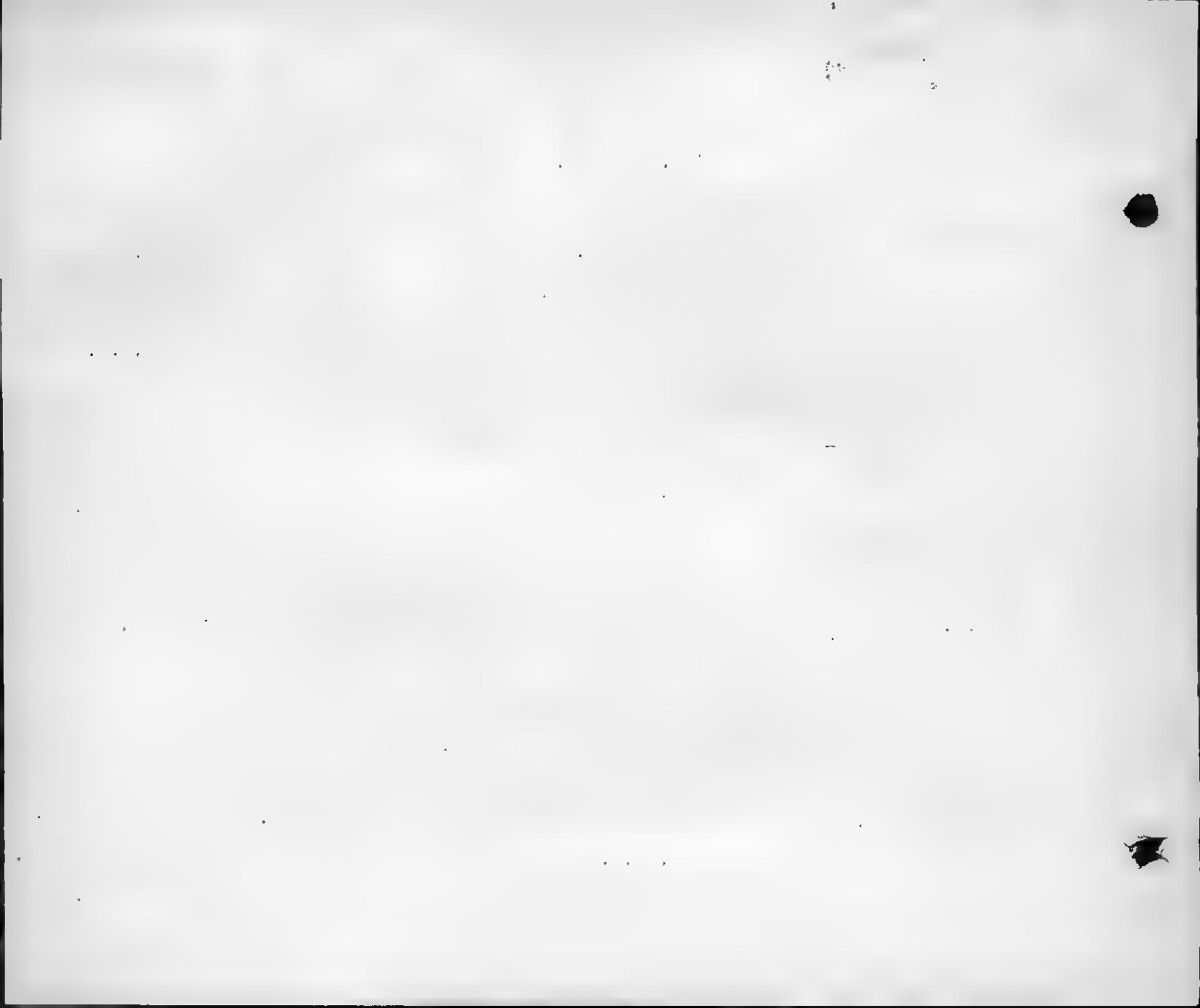
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12449

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12136

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE Maryland		b. COUNTY City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb lyr. 1mo. 8dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11		d. STREET ADDRESS 4400 Evans Chapel Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sarah		First	Middle	Last	4. DATE OF DEATH November	Month	Day	Year
S. SEX Female		6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 5, 1891	9 AGE (In years last birthday) 70 yrs	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days	12 Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Wm V Lloyd Thomas Baker				14. MOTHER'S MAIDEN NAME Mary Benson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17 INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction INTERVAL BETWEEN ONSET AND DEATH days								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 10-14- 19 60 to 11-22- 19 61								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11-22- 19 61 , that (I) (we) last saw the deceased alive on 11-22- 19 61 , and that death occurred at 4 p.m. from the causes and on the date stated above.								
22a. SIGNATURE <i>Agustin del Campo</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-22-61		
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-25-61		23c. NAME OF CEMETERY OR CREMATORIAL GLEN HAVEN		23d. LOCATION (City, town, or county) GLEN BURNIE, MD (State)		
24. FUNERAL DIRECTOR'S SIGNATURE W.M. COOK INC. 1217 ST. PAUL ST.		ADDRESS		25a. REC'D BY REGISTRAR NOV 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12437

12450

1. PLACE OF DEATH

a. COUNTY
Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b

4 yrs. 20 dys.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Springfield State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Anna

Pearl

Bevans

4. SEX

6. COLOR OR RACE

Female

White

10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

February 21, 1879

82 yrs.

9. AGE (in years last birthday) IF UNDER 1 YEAR
Months Days Hours Min.

1735 Abbottston Street

Last

4. DATE OF DEATH

Month

November

Day

29

Year

1961

13. FATHER'S NAME

Lewis Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

No

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Mesenteric thrombosis due to Arteriosclerotic heart disease.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b) arteriosclerosis.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
C.B.S. associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11-9-1957 to 11-29-1961, that (I) (we) last saw the deceased alive on 11-29-1961, and that death occurred at 5:20 a.m. from the causes and on the date stated above.

22e. SIGNATURE

22e. PHYSICIAN'S
NAME (Type)

Agustín del Campo, M.D.

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

Springfield State Hospital, Sykesville, Md.

22b. DATE
SIGNED
11-29-61

23e. BURIAL, CREMATION, REMOVAL (Specify)

23e. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

BURIAL 12/2/61

LONDON PARK Cem. BALTIMORE

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

(State)

L. J. Ruck 5305 Harford Rd.

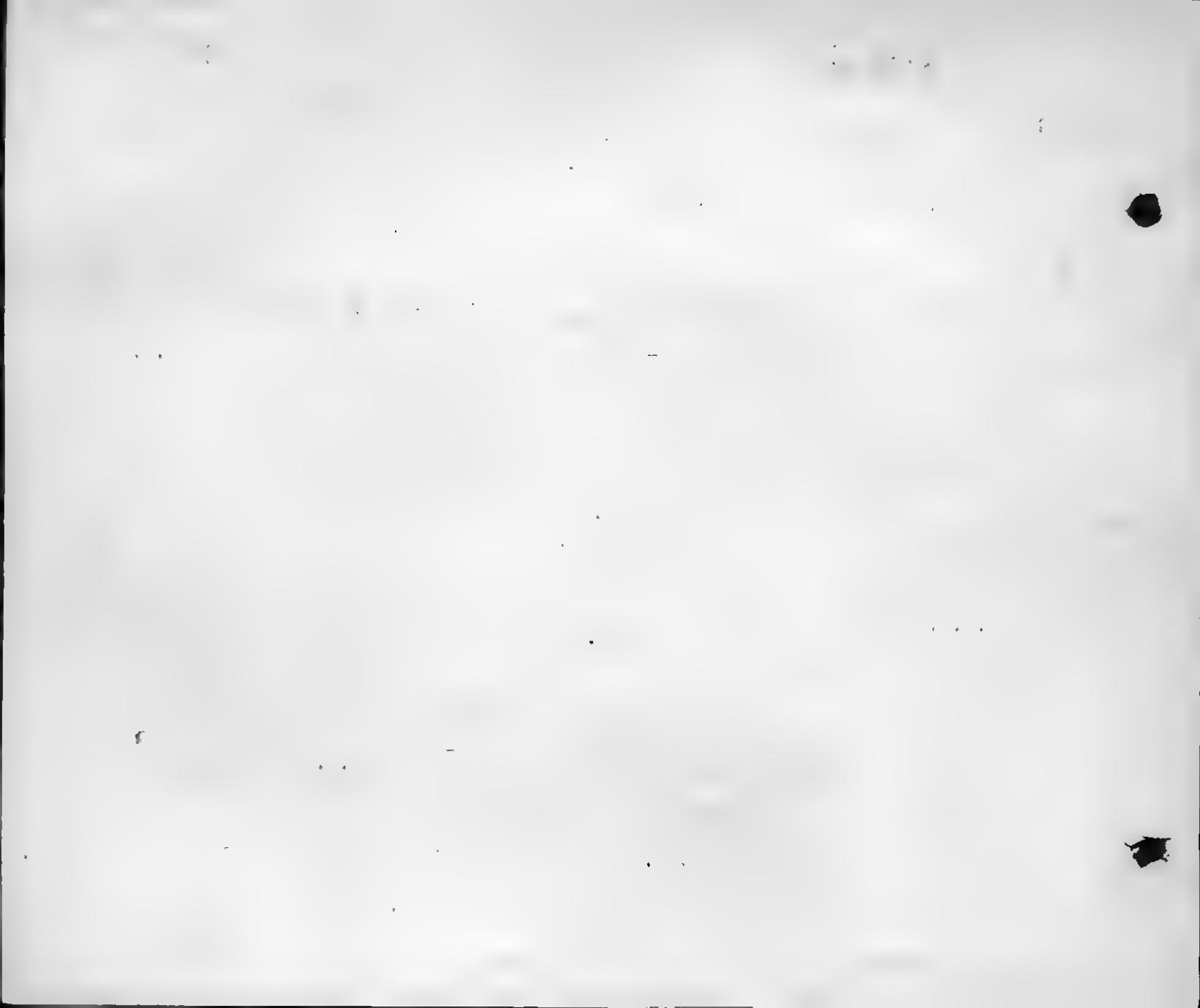
DATE DEC 4 '61

Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12451

CERTIFICATE OF DEATH

12438

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Sykesville		c. LENGTH OF STAY IN 1b 12y-3mo-12d.		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY unknown		
3. NAME OF DECEASED (Type or print)		First James	Middle -----	Last Bird	4. DATE OF DEATH 11 6 1961	Month 11	Day 6	Year 1961		
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> not determined	8. DATE OF BIRTH not determined	9. AGE (In years last birthday) possibly 65	10. IF UNDER 1 YEAR Months 65	11. IF UNDER 24 HRS Days 1/2 yrs	12. Hours Min.		
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? American				
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetis Mellitus X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Cardiac Decompensation INTERVAL BETWEEN ONSET AND DEATH 13 yr. plus at time of death										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenia, hebephrenic type										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) 9/60		(County) 1961	(State)	
21. I certify that (I) (this hospital) attended the deceased from 9/60 to 11-6- , 1961, that (I) (we) last saw the deceased alive on 11-6- , 1961, and that death occurred at 4:11A from the causes and on the date stated above.										
22a. SIGNATURE Yasuo Takahashi		22b. DATE SIGNED 11-6-61								
22c. PHYSICIAN'S NAME (Type) Yasuo Takahashi		22d. ADDRESS Springfield State Hospital								
23a. BURIAL CREMATION REMOVAL (Specify) 11-6-61 M		23b. DATE THEREOF 11-6-61 M		23c. NAME OF CEMETERY OR CREMATORIAL Anacostia		23d. LOCATION (City, town, or county) Baltimore			(State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H Howell		ADDRESS 11-6-61 M		25a. REC'D BY REGISTRAR DATE NOV 10 '61		25b. REGISTRAR'S SIGNATURE C. L. S. T. H. 11-6-61				

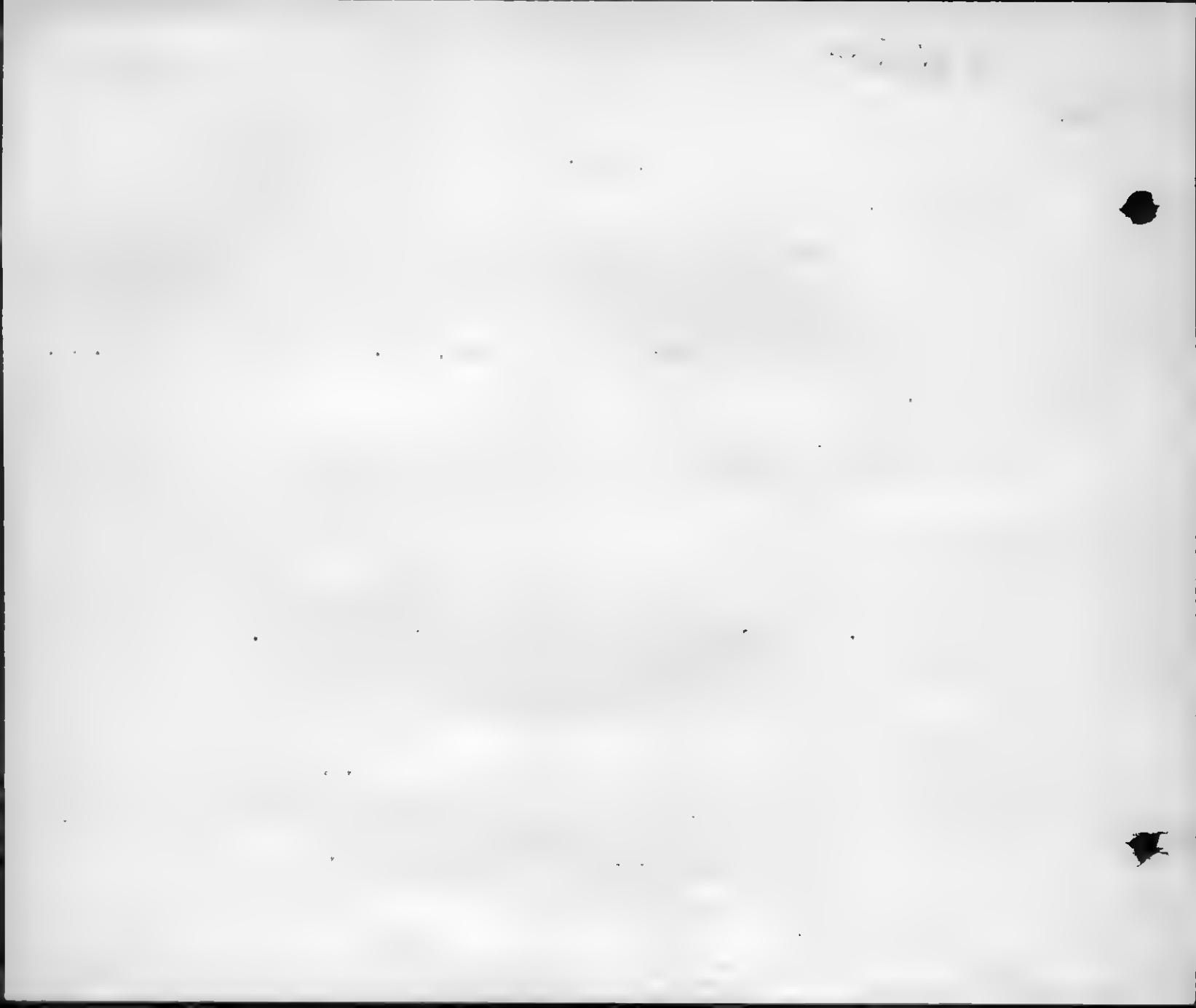


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12452		12439	
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 6 mos./24 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS Frederick Ladiesburg	
3. NAME OF DECEASED (Type or print) Finkle Howard BIRELY		4. DATE OF DEATH 11 - 10, 1961	
5. SEX male 6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8/25/72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) W.M. Fred. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam D. Birely		14. MOTHER'S MAIDEN NAME Jane Anders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral INTERVAL BETWEEN ONSET AND DEATH days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 441X DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with senile brain disease with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Hour a. m. 19 While Not while p. m. at work <input type="checkbox"/> at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 4-18-61 19 to 11-10-61 19 , that (I) (we) last saw the deceased alive on 11-10-61 19 , and that death occurred at 8:15 P.M. causes and on the date stated above			
22a. SIGNATURE Agustin del Campo 22b. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11/13/61		23c. NAME OF CEMETERY OR CREMATORIUM Middleburg Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Skiles C.O. Fuss & Son		23d. LOCATION (City, town, or county) (State) Middleburg, Maryland	
25a. REC'D BY REGISTRAR NOV 14 '61		25b. REGISTRAR'S SIGNATURE Robert S. Kraus	
ADDRESS Taneytown, Maryland			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12453

CERTIFICATE OF DEATH

Reg. No. 12453

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		b. COUNTY CARROLL	
c. LENGTH OF STAY IN 1b 43 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS N. CENTER ST	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OSCAR CHARLES BIXLER	First	Middle	Last
4. DATE OF DEATH NOV. 10 1961	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1891
		WIDOWED <input type="checkbox"/>	9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SIGNAL MAN	10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME THEODORE BIXLER	14. MOTHER'S MAIDEN NAME REBECCA ROYER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —	16. SOCIAL SECURITY NO (If yes, give war or dates of service) —	INFORMANT 705-10-5897 - HARRY BIXLER	Address 129 CITY VIEWWARE WESTMINSTER, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 19614 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO lying cause last. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Hampstead, Md. (County) Hampstead (State) Md.
21. I certify that I attended the deceased from June 12, 1961 to 11-10 1961 , that I last saw the deceased alive on 11-10 1961 and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hampstead, Md. DATE SIGNED 11-11-61			
ACTUAL DEATH TIME 27. C. Porterfield		PHYSICIAN'S NAME (Type) M. C. Porterfield	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/13/61	22c. NAME OF CEMETERY OR CREMATORIAL MEADOW BRANCH	22d. LOCATION (City, town, or county) (State) WESTMINSTER, MD.
23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell.		ADDRESS Westminster Maryland	24a. REC'D BY REGISTRAR DATE NOV 13 '61
			24b. REGISTRAR'S SIGNATURE Arthur S. Kline



12354

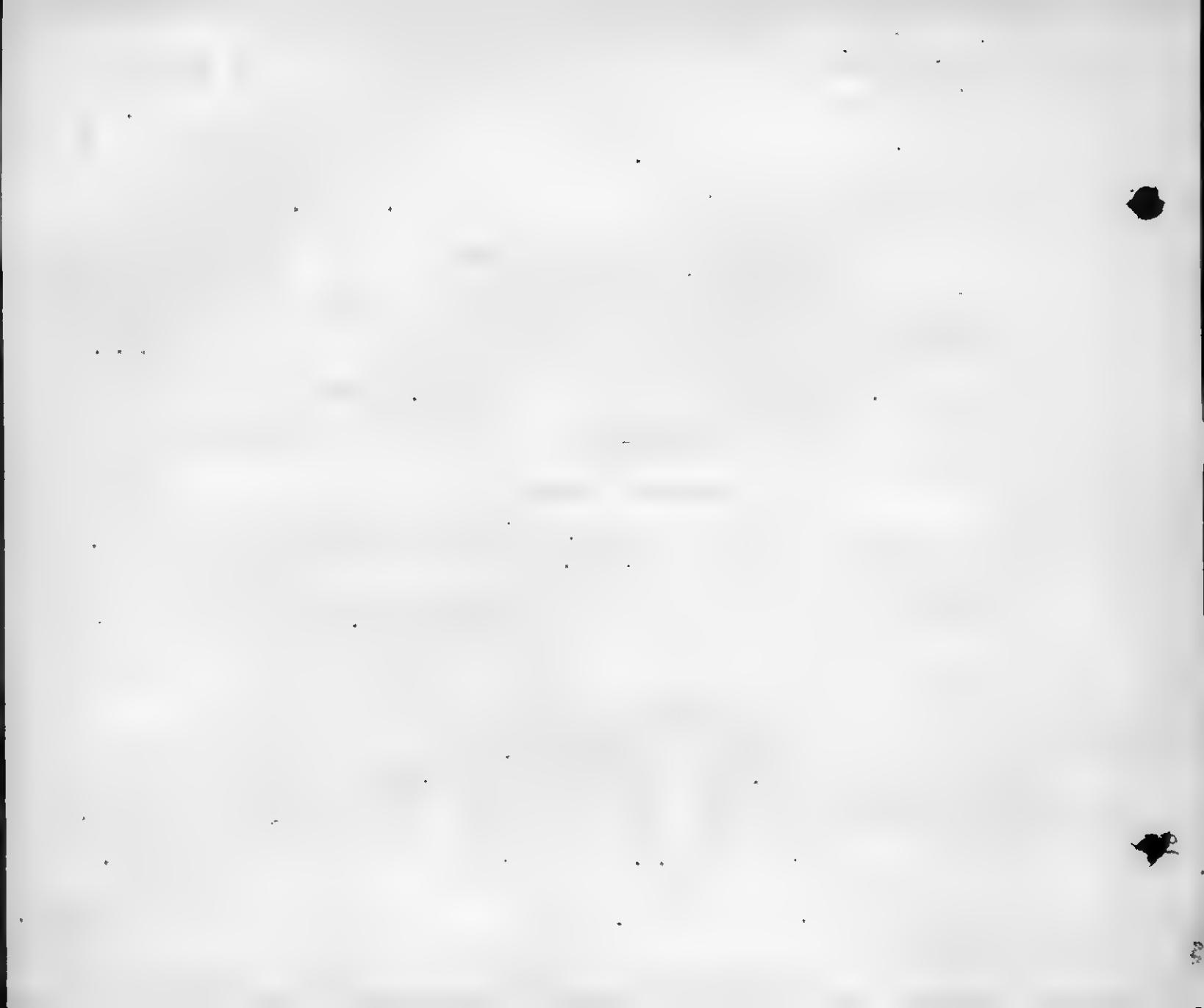
12141

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 

VR A1S (4)
15M 8/59

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3mos. 16days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18		3VC 1-4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2939 St. Paul St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Harold	Middle	Last Bradshaw	4. DATE OF DEATH Month November	Day 16	Year 1961	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH August 27, 1912	9. AGE (In years last birthday) 49 yrs.					
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles H. Bradshaw				14. MOTHER'S MAIDEN NAME Mary A. Hoffman						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO 213-10-4608		17. INFORMANT Springfield Hospital Records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) X Internal hydrocephalus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhagic tumor/of cerebellum blocking the 4th ventricle. DUE TO (c)										
INTERVAL BETWEEN ONSET AND DEATH Days										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sociopathic personality disturbance, alcohol addiction.										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 30, 1961, to November 16, 1961, that (I) (we) last saw the deceased alive on Nov. 15, 1961, and that death occurred at 2:20 AM from the causes and on the date stated above.										
22a. SIGNATURE Agustin del Campo.				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22b. DATE SIGNED 11/16/61			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-19-61		23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cem		23d. LOCATION (City, town, or county) Somerset Co. Md. (State)				
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw Funeral Home		ADDRESS Crisfield, Md.		25a. REC'D BY REGISTRAR NOV 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				



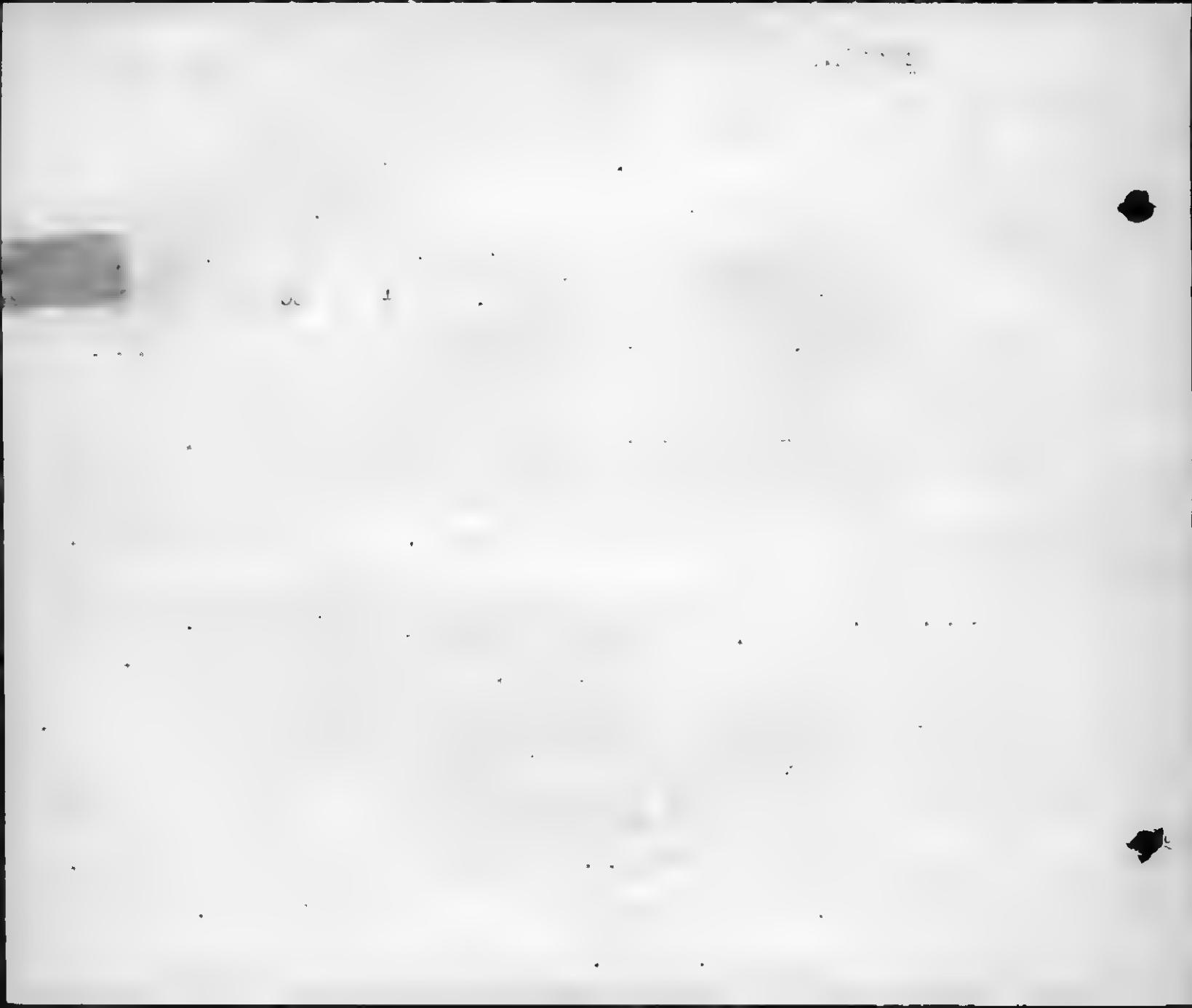
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12455

CERTIFICATE OF DEATH

12142

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11mos. 3days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS Virginia Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles		First	Middle	Last	4. DATE OF DEATH Bricker	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1881		9. AGE (In years from birthday) 80 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad engineer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-07-6814		17. INFORMANT Springfield Hospital Records.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic CVD DUE TO +43 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Generalized arteriosclerosis. DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH Years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase. Fracture, right hip. (Medical Examiner notified; did not accept jurisdiction.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Patient fell on ward.						
20c. TIME OF INJURY Month, Day, Year Hour o. m 11/ 4 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) Hospital		20f. (City or town) Sykesville	(County) Carroll	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 12/16/60 to 11/19/61 , that (I) (we) last saw the deceased alive on 11/19/61 , and that death occurred at 9 A.M. from the causes and on the date stated above.								
22a. SIGNATURE Agustin del Campo MD		22b. DATE SIGNED 11/19/61		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) 11/19/61		23b. DATE THEREOF Nov. 24, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge		23d. LOCATION (City, town, or county) Baltimore, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE John Cook, Inc		ADDRESS 1217 St. Paul St.		25a. REC'D BY REGISTRAR DMOV 27 '61		25b. REGISTRAR'S SIGNATURE John S. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

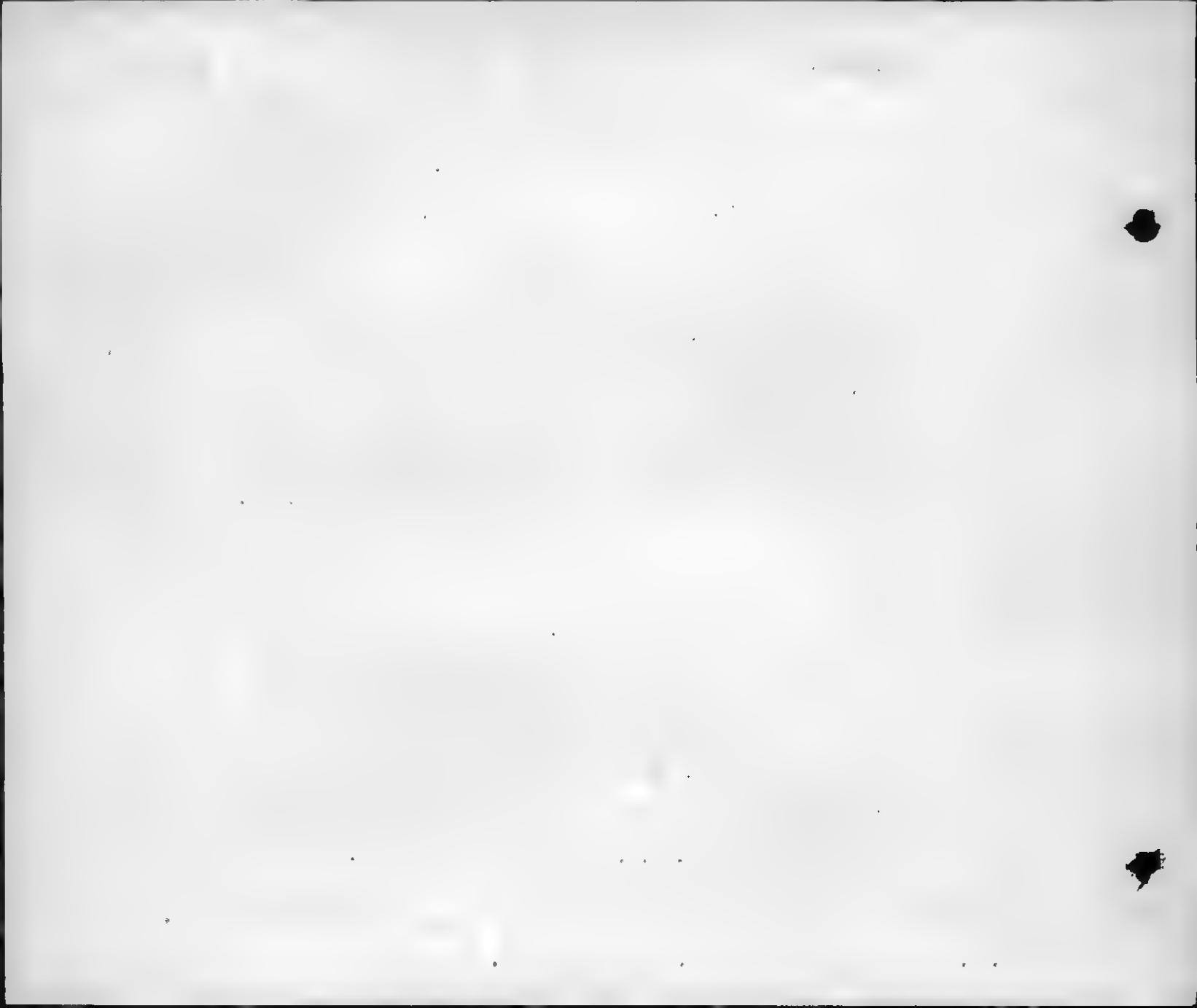
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12456

12443

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 22 yrs 7 mos 12 d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11, Maryland		3. 11 1 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 700 W. 40th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Katherine	Middle T.	Last Brown	4. DATE OF DEATH November 10, 1961	Month November	Day 10	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1879		9. AGE (in years lost birthday) 82 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael X MURRAY		14. MOTHER'S MAIDEN NAME Kate Nooney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with failure.</u>							
420.11 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus C.B.S. associated with alcohol intox. with psychotic reaction.							
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-28-1939 to 11-10-1961, that (I) (we) last saw the deceased alive on 11-10-1961, and that death occurred at 8 AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Agustin del Campo</u>		M.D. <input type="checkbox"/> ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>	
22b. DATE SIGNED 11-10-61							
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield St. Hospital, Sykesville, Md.					
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/13/61		23c. NAME OF CEMETERY OR CREMATORIUM CATHEDRAL		23d. LOCATION (City, town, or county) BALTIMORE, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. MEARS & SON 805 N. CALVERT St.		25a. REC'D BY REGISTRAR NOV 13 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Krause			



TO HOSPITAL ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it is 24 hours or more after the death, the physician or attending physician, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12437

CERTIFICATE OF DEATH

12444

1. PLACE OF DEATH
a. COUNTY

Carroll

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Westover

c. LENGTH OF STAY IN lb

MARYLAND
30 MIN.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Carroll County General

3. NAME OF DECEASED
(Type or print)

Fst. Middle
HOBART B. BRUBAKER

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

MD.

b. COUNTY

BALTIMORE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

REISTERSTOWN

d. STREET ADDRESS

CHURCH ROAD

a. IS RESIDENCE
ON A FARM?
YES NO

Day Year
Month Day Year
1961

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Aug. 6-1896

9. AGE (In years
last birthday)

65 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if not regular)

Machinist AT Edgewood

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Penna.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Amos R Brubaker

14. MOTHER'S MAIDEN NAME

Alice Baum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURY NO

(Yes, no, or unknown) (If yes, give rank, dates of service)

YES WW I 218-05-1346

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

2. CORONARY THROMBOSIS

INTERVAL BETWEEN
ONSET AND DEATH
1 HR.

DUE TO
(b)

3. ARTERIOSCLEROTIC C.V. DISEASE

DUE TO
(c)

4. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

5. PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

6. PART IV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

7. PART V. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

8. PART VI. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

9. PART VII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

10. PART VIII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

11. PART IX. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

12. PART X. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

13. PART XI. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

14. PART XII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

15. PART XIII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

16. PART XIV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

17. PART XV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

18. PART XVI. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 1956 to Nov. 14, 1961, that (I) (we) last

saw the deceased alive on Nov. 14, 1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

MARTIN E. STRODEL

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

J.F. Eline, Sons, Reisterstown Md

ADDRESS

25a. REC'D BY REGISTRAR

NOV 17 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

DATE



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12458

CERTIFICATE OF DEATH

12445

TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be readied by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Winfield		b. COUNTY Maryland	
c. LENGTH OF STAY IN 1b 57 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Winfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P. O. Sykesville		d. STREET ADDRESS P. O. Sykesville	
3. NAME OF DECEASED (Type or print) LULA		First M.	Middle BUSHEY
4. DATE OF DEATH November 20, 1961	Month Nov	Day 20	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
10c. BIRTHPLACE (State or foreign country) Maryland		11. AGE (In years last birthday) 79 yrs.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Koller	14. MOTHER'S MAIDEN NAME Elizabeth Bressler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Mr. John S. Bushey, Same as above	17. INFORMANT
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, hypertension, 33.1 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Caterosclerosis generalized. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1960 to 1961	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 to Nov , 1961, that (I) (we) last saw the deceased alive on 20 Nov 1961 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Howard E. Hall		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 21 Nov 61
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M. D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 11-22-1961	23c. NAME OF CEMETERY OR CREMATORIUM Westminster Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		23d. LOCATION (City, town, or county) Westminster, Maryland	
		25a. REC'D BY REGISTRAR DATE 10V 22 '61	25b. REGISTRAR'S SIGNATURE Orlma S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12469

CERTIFICATE OF DEATH

12146

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Carroll

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b

2y. 2m. 7d.

Springfield State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED
WIDOWED NEVER MARRIED DIVORCED

Byrne

8. DATE OF BIRTH

9/19/94

9. AGE (In years
last birthday)

67 yrs.

10. IF UNDER 1 YEAR
Months Dey11. IF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Practical nurse

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Wesley Garrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give war and dates of service)

no 217-36-5043 Springfield Hospital records, Sykesville, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)Metastatic carcinoma of both lungs &
mediastinum.INTERVAL BETWEEN
ONSET AND DEATH

Months.

163 X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CBS assoc. with circulatory disturbance with psychotic reaction.
(Status after mastectomy for adenocarcinoma.)19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.,
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Month, Day, Year

Hour
a.m.
p.m.

19

20d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town,

(County)

(State)

21. I certify that (this hospital) attended the deceased from 9/8/..... 169 PM 11/15/..... 1961, that (we) last
saw the deceased alive on 11/15/..... 1961, and that death occurred at 6:25 PM from the causes and on the date stated above.

22a. SIGNATURE

Naci B. Buyukunsal

22c. PHYSICIAN'S
NAME (Type)

Naci Buyukunsal, M.D.

ATTENDING
M.D. PHYS.

22d. ADDRESS

MED. DIRECTOR STAFF PHYS. Springfield State Hospital
Sykesville, Maryland22b. DATE
SIGNED

11/16/61

23a. BURIAL, CREMATION
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL
Forest Oak

23d. LOCATION (City, town or county)

(State)

Gaithersburg

24. FUNERAL DIRECTOR'S SIGNATURE

Ernest J. Gartner, Gaithersburg, Md.

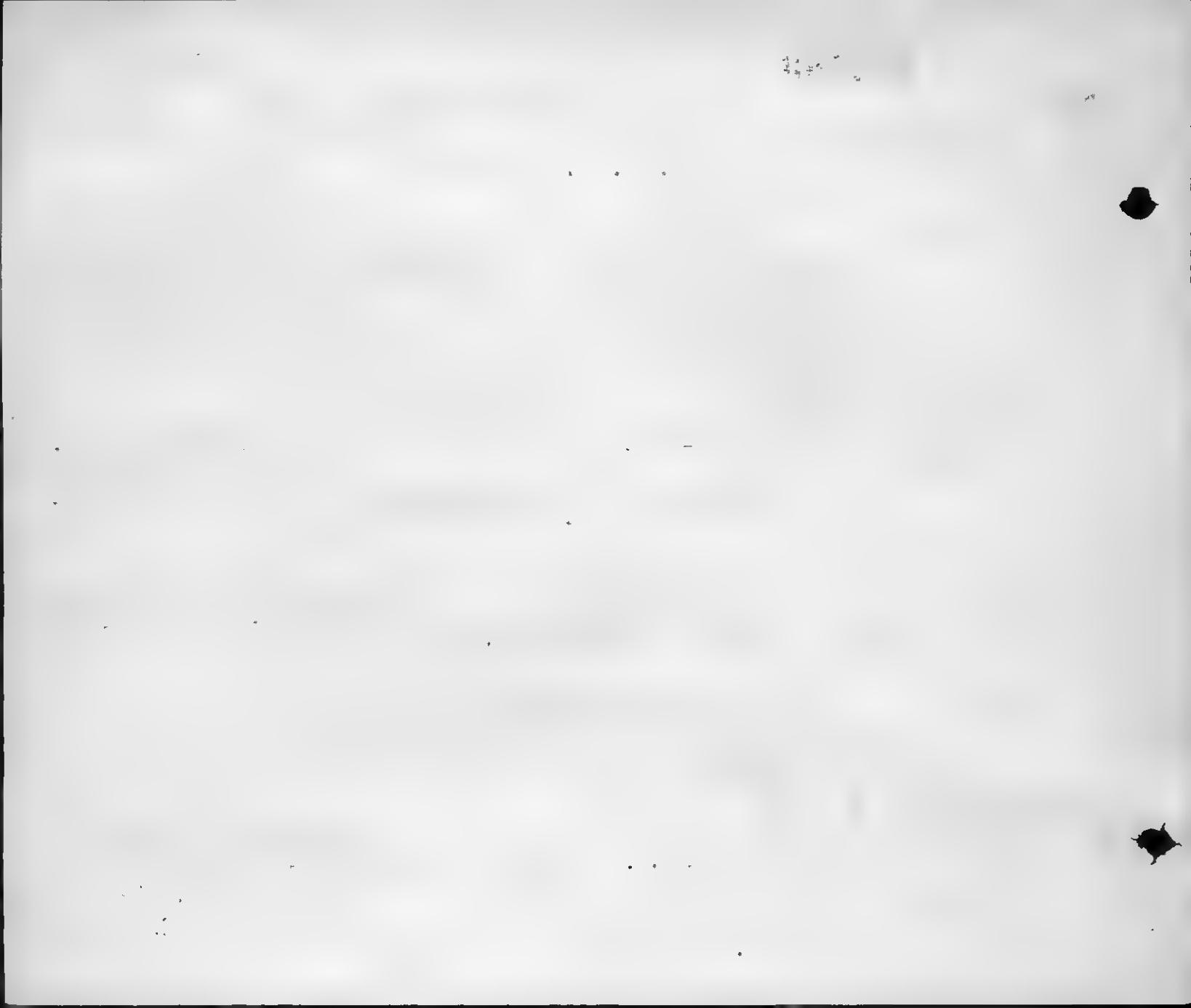
ADDRESS

25a. REC'D BY REGISTRAR

DATE NOV 21 '61

25b. REGISTRAR'S SIGNATURE

Charles S. Trahan



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 days are required, the physician or attending physician, after this certificate has been signed by the attending physician, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

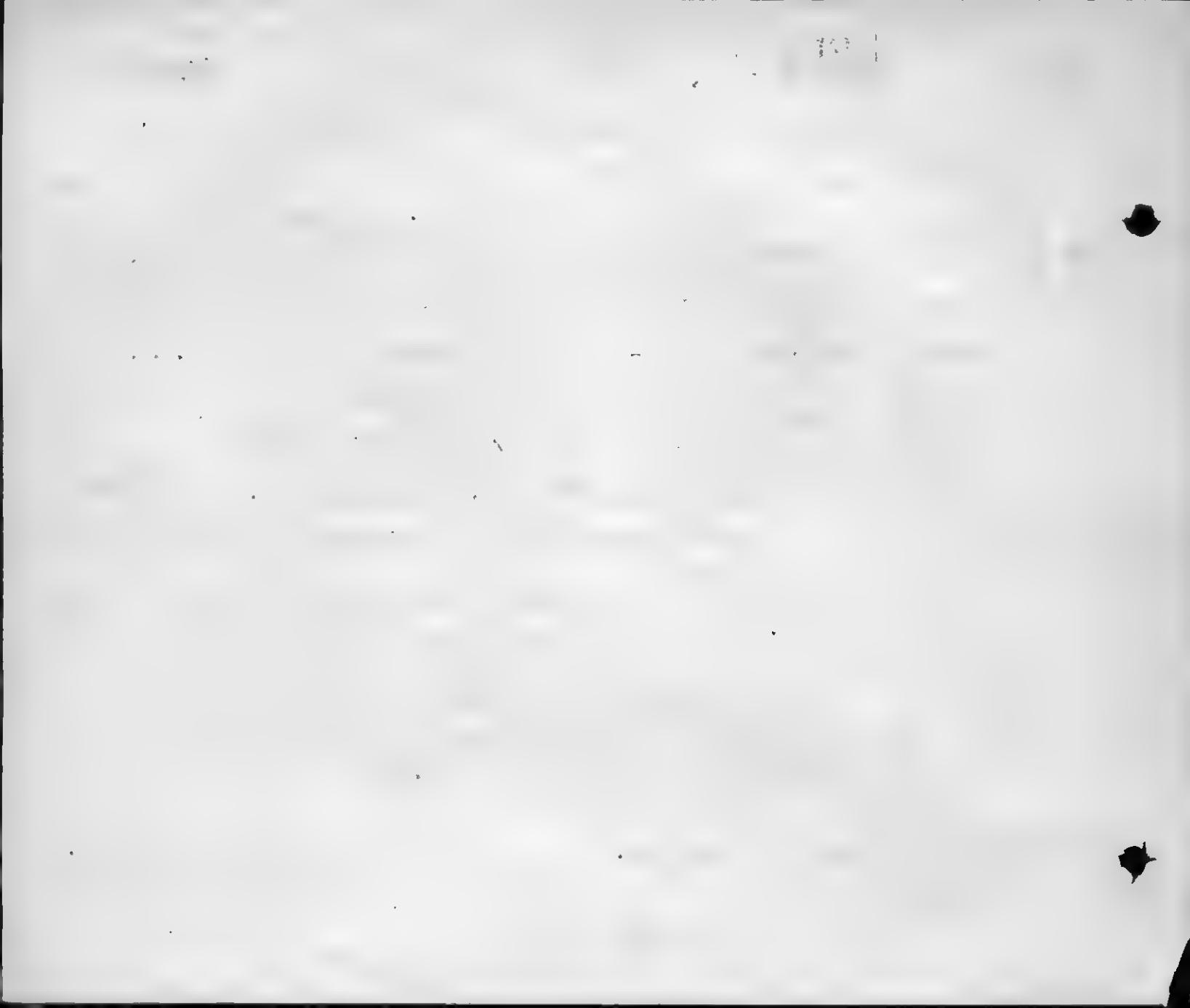
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12460

CERTIFICATE OF DEATH

12442

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 1	
3. NAME OF DECEASED (Type or print) George		d. STREET ADDRESS 604 N. Eutaw Street	
4. DATE OF DEATH Last Cole		Month November	
5. SEX Male		Day 24, 1961	
6. COLOR OR RACE White		Year 1961	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1877	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant & Auditor		9. AGE (In years last birthday) IF UNDER 1 YEAR 84 yrs. Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME George Cole		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or date of service No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Springfield Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH Weeks Days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521X Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Multiple Lung Abscesses, type undetermined.		DUE TO (b) Bronchopneumonia, possibly aspiration. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a. Diabetes Mellitus.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/18/61 , 1961, to 11/24/61 , 1961, that (I) (we) last saw the deceased alive on 11/24/61 , 1961, and that death occurred 11:45PM from the causes and on the date stated above.		22b. DATE 11/25/61	
22a. SIGNATURE Agustin del Campo		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Springfield Hospital, Sykesville, Md.	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		23d. LOCATION (City, town or county) (State) Baltimore Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV 24-1961	
23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE C. F. Evans & Son		25a. REC'D BY REGISTRAR DATE NOV 28 '61	
ADDRESS 8802 Hartcrv Rd.		25b. REGISTRAR'S SIGNATURE Charles E. Evans	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be returned by the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

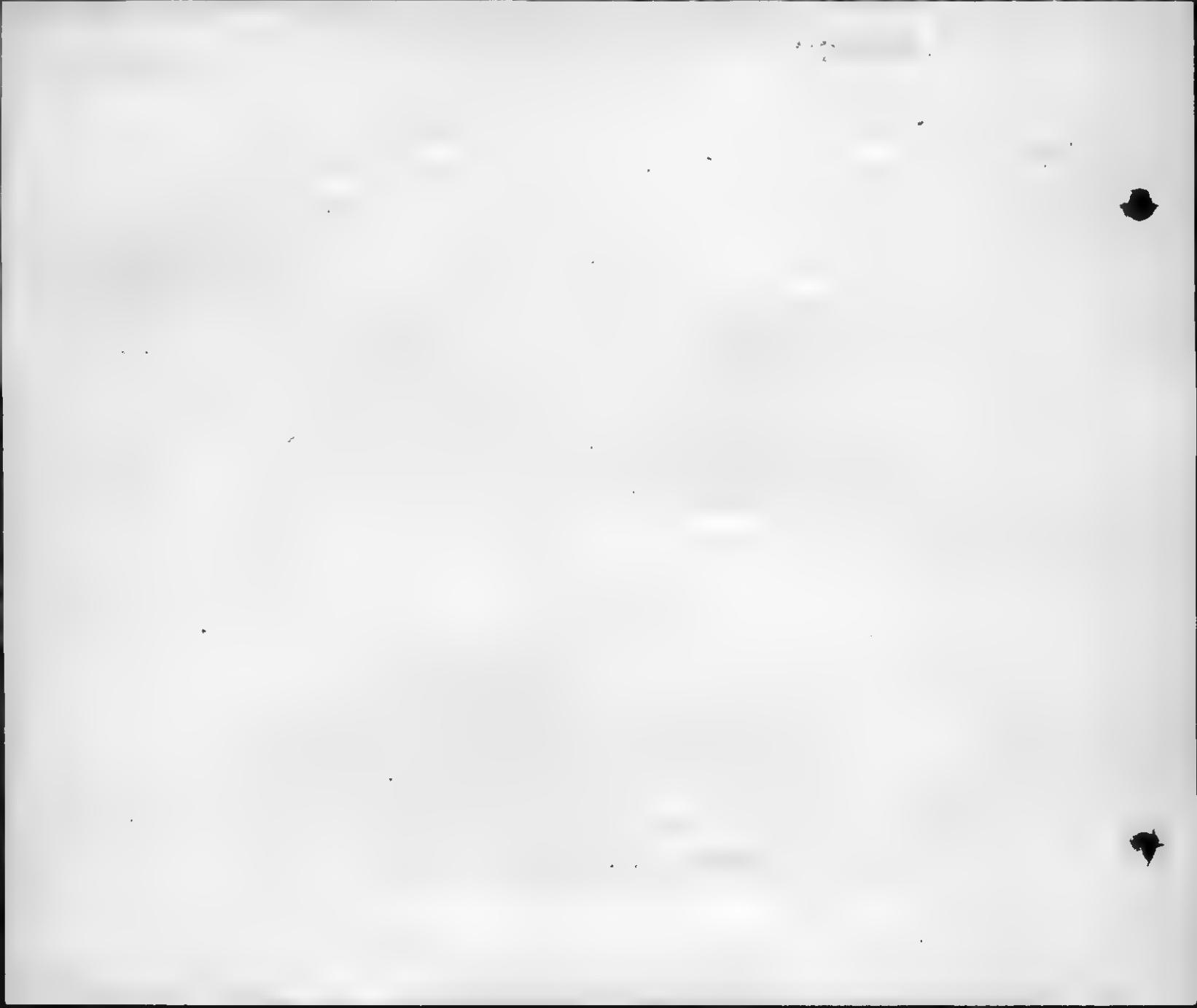
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12461

CERTIFICATE OF DEATH

12448

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 mos. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		d. STREET ADDRESS 111 Lee Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				4. DATE OF DEATH 10-30-1893		Month 11	Day 4 , Year 1961
3. NAME OF DECEASED (Type or print) James		First James	Middle Lloyd	Last CREGER			
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10-30-1893	9. AGE (in years last birthday) 68 yrs	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS. Days Hours Min
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman - retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Creger		14. MOTHER'S MAIDEN NAME Norma Uckley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of serv. no		16. SOCIAL SECURITY NO. 577-10-9032		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH days	
491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
CBS assoc. with cerebral arteriosclerosis with psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour a. m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/29/61, 19, to 11/4/61, 19, that (I) (we) last saw the deceased alive on 11/4/61, 19, and that death occurred at 98 M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Naci N. Buyukunsal</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11/4/61
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Sykesville, Maryland					
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 11/7/61		23c. NAME OF CEMETERY OR CREMATORIAL Roanoke Va.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Rinaldi Funeral Home</i>		ADDRESS 7400 Ga. Ave. N.W., D.C.		25a. REC'D BY REGISTRAR DATE NOV 6 '61		25b. REGISTRAR'S SIGNATURE <i>John H. Haas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours are not available, the physician or attending physician, after this certificate has been signed by the hospital or attending physician, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN 1b by. 4m. 15d.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Richard		d. STREET ADDRESS 706 N. Lakewood Ave.	
First Middle Leon		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male		4. DATE OF DEATH 11 27 19 61	
6. COLOR OR RACE white		5. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED 8-10-01	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cullender		14. MOTHER'S MAIDEN NAME Margaret Mudd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) yes WW-I		16. SOCIAL SECURITY NO. 17. INFORMANT 212-05-2822 Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.		19. INTERVAL BETWEEN ONSET AND DEATH Days Bronchial pneumonia	
(b) DUE TO Multiple infarctions in the brain arteriosclerosis.		Days	
(c) DUE TO Arteriosclerotic heart disease due to arteriosclerosis.		Days	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Involutional psychotic reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. ---		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. (City or town) ---		20f. (County) (State) ---	
21. I certify that (I) (this hospital) attended the deceased from..... 7-12- 19 57, to..... 11-27- 19 61 that (I) (we) last saw the deceased alive on..... 11-27- 19 61, and that death occurred at 4:30 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 11-27-61	
22a. SIGNATURE <i>Agustín del Campo, M.D.</i>		ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Agustín del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-1-61		23b. DATE THEREOF 12-1-61	
23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer		23d. LOCATION (City, town or county) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		25a. REC'D BY REGISTRAR DATE NOV 20 '61	
ADDRESS 5305 Harford Rd		25b. REGISTRAR'S SIGNATURE John & Anna	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

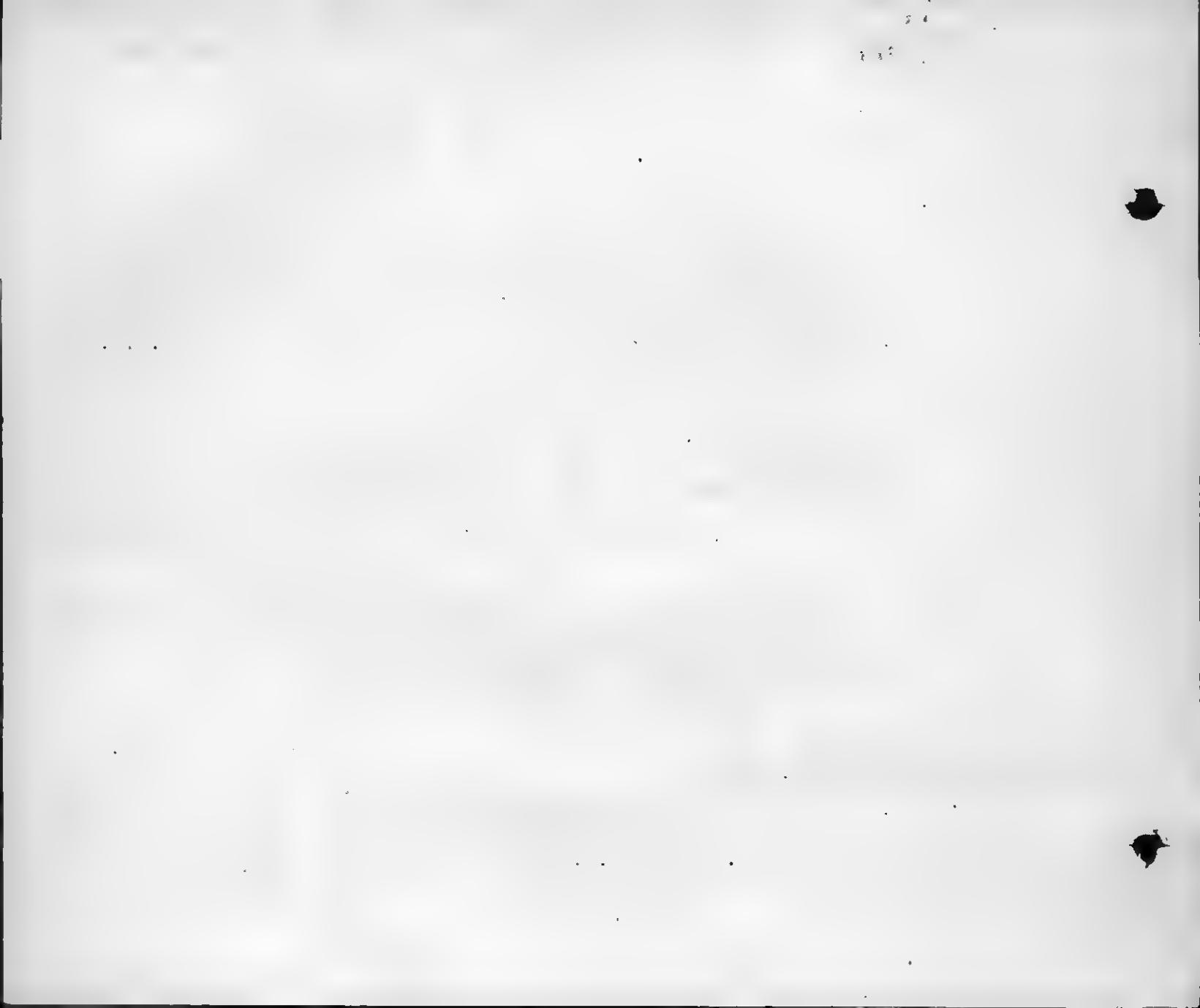
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12463

CERTIFICATE OF DEATH

12150

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville.		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 154 BEDFORD STREET		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First ELIZABETH	Middle	Last DUCKWORTH	4. DATE OF DEATH 11	Month 11	Day 23	Year 1961
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-19-81		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES DUCKWORTH			14. MOTHER'S MAIDEN NAME ELLEN DUCKWORTH			Address Records of Springfield State Hospital		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH Years		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerotic heart disease						
420.1 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		DUE TO (b) Coronary arteriosclerosis			Years			
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 7BS associated with cerebral arteriosclerosis, with psychotic						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) reaction						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that (s) (this hospital) attended the deceased from 10-23-1961 to 11-23-1961, that (s) (we) last saw the deceased alive on 11-23-1961, and that death occurred at 5:30, from the causes and on the date stated above								
22a. SIGNATURE Gertrude M. Gross, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/24/61
22c. PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Md.						
23a. BUR. A., CREMAT. ON, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/61		23c. NAME OF CEMETERY OR CREMATORIAL Rosehill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR DATE NOV 27 '61		25b. REGISTRAR'S SIGNATURE Ruth E. Silcox		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

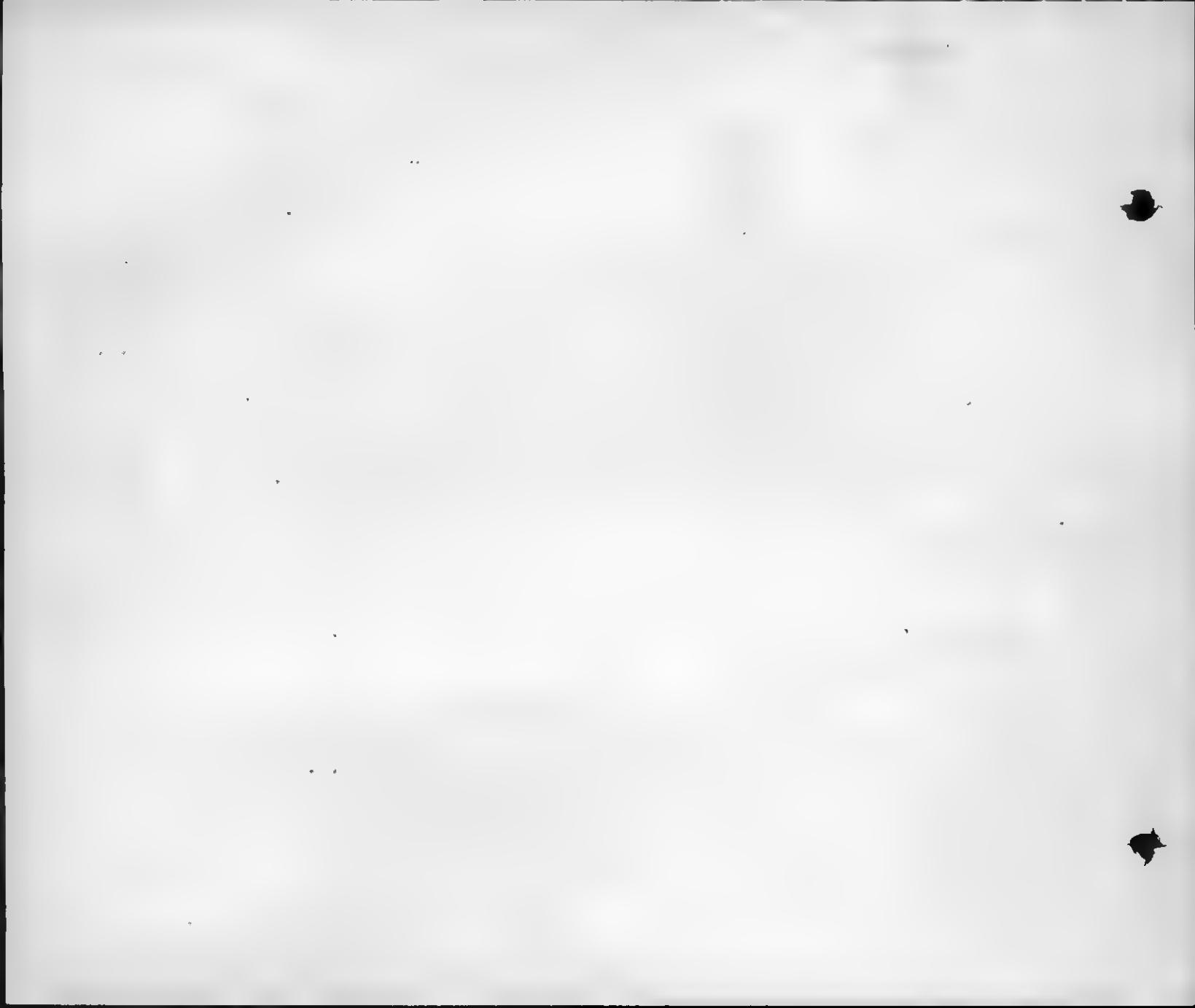
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12464

CERTIFICATE OF DEATH

12151

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE Maryland		b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #13		d. STREET ADDRESS 3436 Erdman Ave. - 3436	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Annie	Middle Bergetha	Last EARHART	4. DATE OF DEATH 11-11-1961	Month 11	Day 11	Year 1961
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-76	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Smith		14. MOTHER'S MAIDEN NAME Margaret Hoffman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO		17. INFORMANT		Address Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS with senile brain disease with psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-10-61 19 to 11-11-61 19, that (I) (we) last saw the deceased alive on 11-11-61 19, and that death occurred at 11:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-11-61			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/15/61		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery		23d. LOCATION (City, town, or county) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane		ADDRESS		25a. REG'D BY REGISTRAR NOV 14 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



1
FOR STATE
HEALTH DEPT.

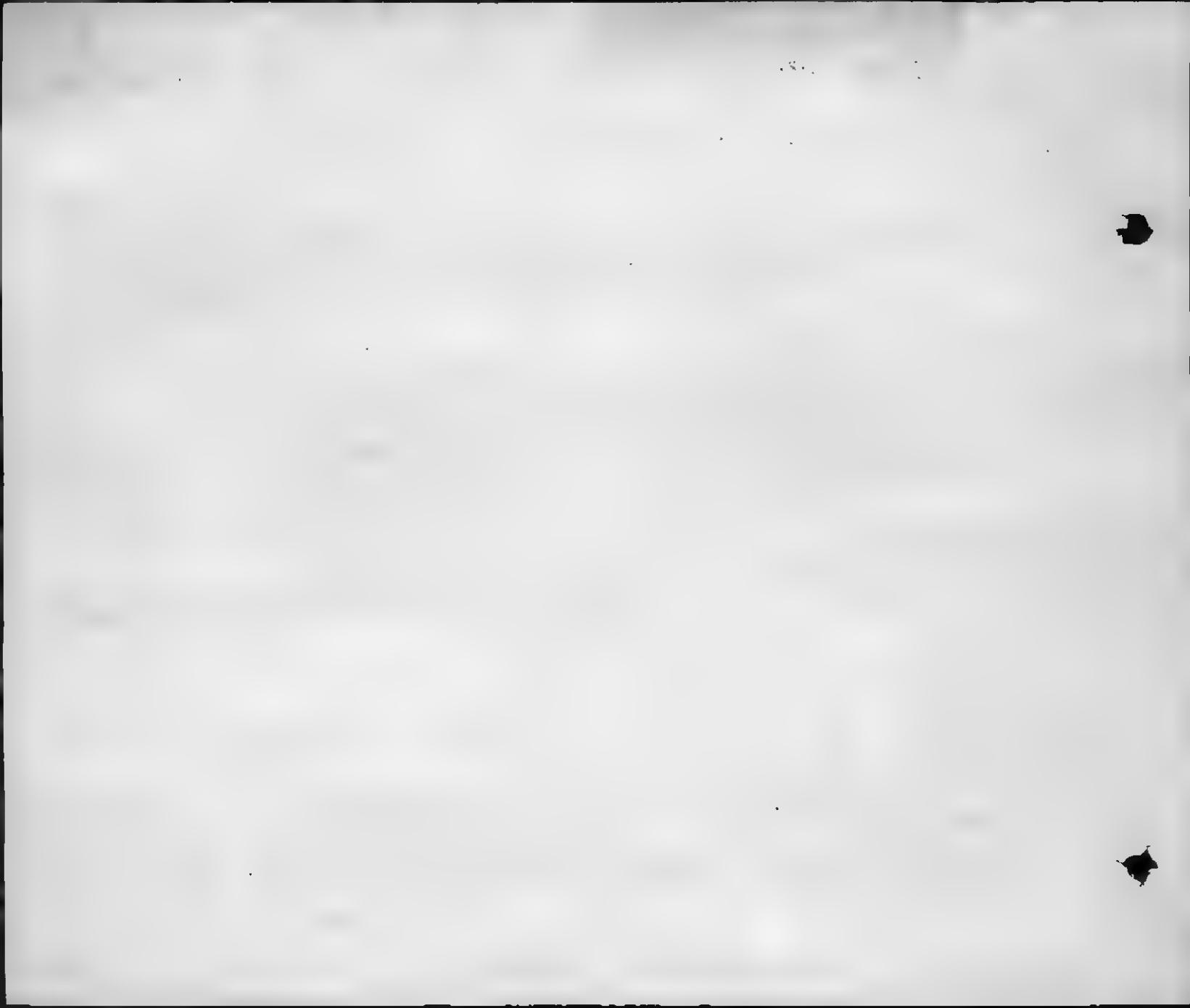
TO DR. MEDICAL DIRECTOR: This certificate should be executed within 24 hours after death. If it is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16 Film 301 11-12465 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12465 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12152

1. PLACE OF DEATH a. COUNTY CARROLL	2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL						
c. LENGTH OF STAY IN lb MINUTES	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS RURAL						
3. NAME OF DECEASED (Type or print) ELI MONROE ECKER	4. DATE OF DEATH Month Day Year NOV 18 1961						
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH MAY 11- 1929	9. AGE (In years last birthday) 32 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAY LABORER	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME CARROLL H ECKER	14. MOTHER'S MAIDEN NAME ELIZABETH KILER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war, ordnance or date of service) NO	16. SOCIAL SECURITY NO. 214-28-5159	17. INFORMANT RAYMOND ECKER, NEW WINDSOR, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture - dislocation cervical vertebrae	INTERVAL BETWEEN ONSET AND DEATH None						
812 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Struck by automobile	20c. TIME OF INJURY Month, Day, Year Hour 8:45 p.m. 11-18-1961	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) New Windsor	(County) Carroll	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>James T. Marsh</i> EXAMINER'S NAME (Type) JAMES T. MARSH						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov 21- 1961	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS LINGANORE CEM. UNIONVILLE MD	22d. LOCATION (City, town, or country) Carroll Co	DATE SIGNED 11/18/61			
23. FUNERAL DIRECTOR DN Hartley & Son, New Windsor, Md	ADDRESS 222 '61	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>James T. Marsh</i>					
VS. A15ME 5M 7/59							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12466

CERTIFICATE OF DEATH

12452

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b

28 Yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Springfield State Hospital

3. NAME OF
DECEASED
(Type or print)First
William
Middle
Frank

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

b. COUNTY

Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Avondale, Maryland

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO

5. SEX

6. COLOR OR RACE

Male | White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED Last
Ermer
Month
November
Day
22
Year
1961

8. DATE OF BIRTH

2-23-87

9. AGE (In years
at birthday)74
yrs.IF UNDER 1 YEAR
Months
DaysIF UNDER 24 HRS.
Hours
Min.10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farm Labor

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or fore'gn country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Anthony Ermer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17

INFORMANT

Address

Springfield State Hospital

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH

1 Day

420.1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last
} (b)
DUE TO
} (c)
DUE TO

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Schizophrenia, other and unspecified

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.20d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County)
(State)

7-1-33

11-22-61

21. I certify that (I) (this hospital) attended the deceased from 7-1-33 to 11-22-61, 19 , that (I) (we) last
saw the deceased alive on 11-22-61, 19 , and that death occurred at 8:45P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)M.D.
ATTENDING
PHYS.MED.
DIRECTOR
STAFF
PHYS.22b. DATE
SIGNED
11-23-61

22d. ADDRESS

SYKESVILLE MD

23b. DATE THEREOF
REMOVAL (Specify)

24 FUNERAL DIRECTOR'S SIGNATURE

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)
(State)

BURIAL Nov 25-1961

WESTMINSTER

WESTMINSTER

MD

ADDRESS

25a. REC'D BY REGISTRAR

DA NOV 27 '61

25b. REGISTRAR'S SIGNATURE

Curtis S. Thomas

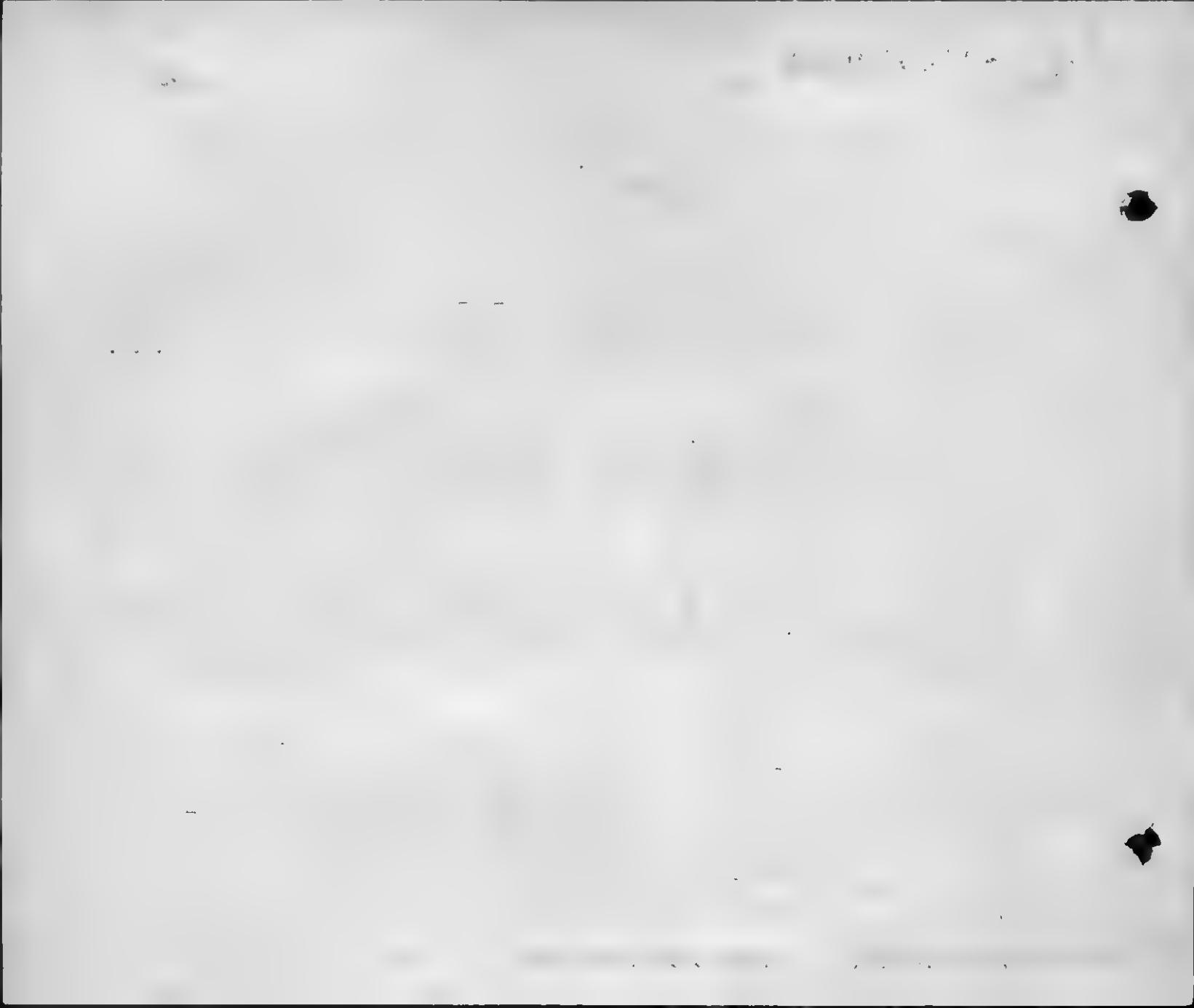
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15

M

1

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 from 6000 1/4/61 1wk

1. PLACE OF DEATH
a. COUNTY **Carroll** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Sykesville P.O.**
rural Eldersberg LENGTH OF STAY IN 1b **5 yrs**

c. LENGTH OF STAY IN 1b **5 yrs**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **Oakland Mill Rd.**

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE **Maryland** b. COUNTY **Carroll**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **rural Eldersberg (Sykesville P.O.)**

d. STREET ADDRESS **Oakland Mill Rd.**

e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED (Type or print) **Alice** First **A.** Middle

4. DATE OF DEATH **Nov. 21 1961**

Lost Month Day Year

5. SEX **Female** **6. COLOR OR RACE** **White** **7. MARRIED** **NEVER MARRIED** **8. DATE OF BIRTH** **1892** **9. AGE (in years at last birthday)** **69** **F UNDER 1 YEAR** **IF UNDER 24 HRS.**

WIDOWED DIVORCED **June 16, 1902** Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Maryland**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Alexander A. Tucker**

14. MOTHER'S MAIDEN NAME **Mary Jane Grimes**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **no** **16. SOCIAL SECURITY NO.** **215-09-3645B** **17. INFORMANT** **Charles Fowler, Oakland Mill Rd.** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: **Myocardial Infarction** INTERVAL BETWEEN ONSET AND DEATH **30 min**

IMMEDIATE CAUSE (a) **420.1**

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT WAS UNDERLYING **OR CONTRIBUTING** **CAUSE OF DEATH** (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year **20d. INJURY OCCURRED** While Not while at work at work **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** (County) (State)

Hour o. m. **19** p. m.

21. I certify that (I) (this hospital) attended the deceased from **July 24, 1961** **to Nov. 21, 1961** **that (I) (we) last saw the deceased alive on** **Nov 21 1961**, and that death occurred at **5 AM**, from the causes and on the date stated above

22a. SIGNATURE *Ronald R. Berger, M.D.* **22b. DATE SIGNED** **Nov. 21, 1961**

22c. PHYSICIAN'S NAME (Type) **Ronald R. Berger, M.D.** **22d. ADDRESS** **8501 Liberty Road, Balto. 7, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** **23b. DATE THEREOF** **11-24-61** **23c. NAME OF CEMETERY OR CREMATORIAL** **Holy Family Church Cem.** **23d. LOCATION (City, town, or county)** (State) **Harrisonville, Maryland**

24. FUNERAL-DIRECTOR'S SIGNATURE *Ronald R. Berger* **25a. REC'D BY REGISTRAR** **25b. REGISTRAR'S SIGNATURE** **DATE NOV 22 '61** *Curley S. Trahan*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12468

CERTIFICATE OF DEATH

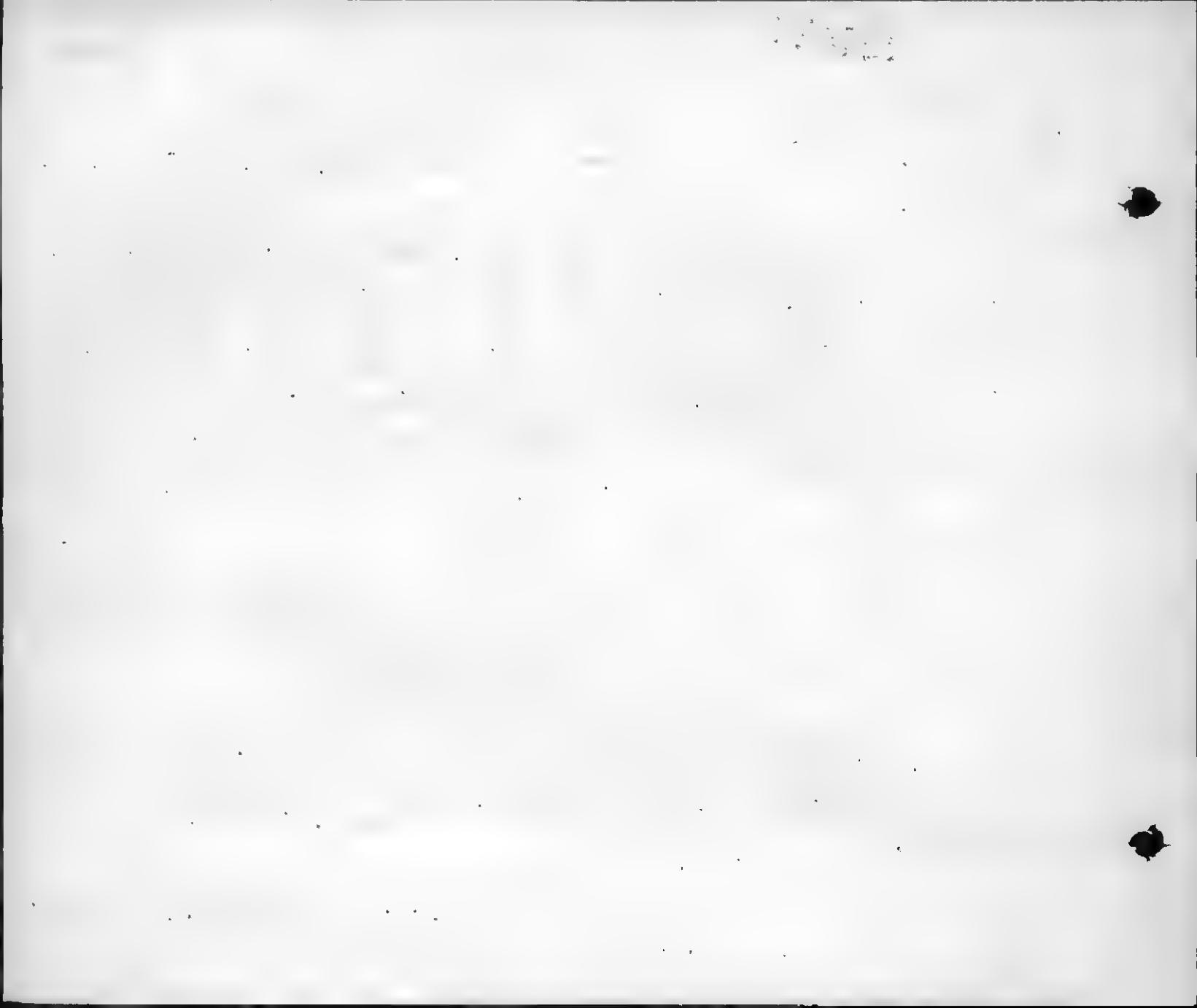
Reg. Dist. No.

12455

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If out'side corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i>		c. LENGTH OF STAY IN 1b 71 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Westminster, Md., Rd #6</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster, Rd #6</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Laura Catherine Frick</i>		First <i>Laura</i>	Middle <i>Catherine</i>
Last <i>Frick</i>		4. DATE OF DEATH Month <i>NOV.</i> Day <i>13</i> Year <i>1961</i>	Month <i>NOV.</i> Day <i>13</i> Year <i>1961</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 29, 1890</i>
9. AGE (In years last birthday) <i>71 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>	11. BIRTHPLACE (State or foreign country) <i>M. Maryland Carroll Md. U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY? <i>M. Maryland Carroll Md. U.S.A.</i>
13. FATHER'S NAME <i>Frederick Mager</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Mager</i>	INFORMANT <i>Adrian M. Frick, Westminster Md.</i> Address <i>Rd #6</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i>—</i>	17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Disease</i> DUE TO <i>442X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension & Arteriosclerosis</i> DUE TO <i>—</i> (c) <i>Arteriosclerosis</i> DUE TO <i>—</i> INTERVAL BETWEEN ONSET AND DEATH <i>6-7 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? IF EITHER, NOTIFY MEDICAL EXAMINER <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>	20d. INJURY OCCURRED While <i>—</i> Not while <i>—</i> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>
21. I certify that I attended the deceased from <i>Oct 29, 1959</i> to <i>Nov 13, 1961</i> , that I last saw the deceased alive on <i>Oct 13, 1961</i> , and that death occurred at <i>10:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Westminster, Md.</i> DATE SIGNED <i>11/14/61</i>			
ACTUAL SIGNATURE <i>W. Glenn Speicher</i>	PHYSICIAN'S NAME (Type) <i>W. GLENN SPEICHER</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/16/61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bear Park Mort. Cemetery, Bear Westminster, Md.</i>	22d. LOCATION (City, town, or county) <i>Bear Westminster, Md.</i> (State) <i>—</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers Jr., Westminster, Md.</i>		ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR <i>NOV 17 '61</i> DATE <i>NOV 17 '61</i>
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITALS: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be re-used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

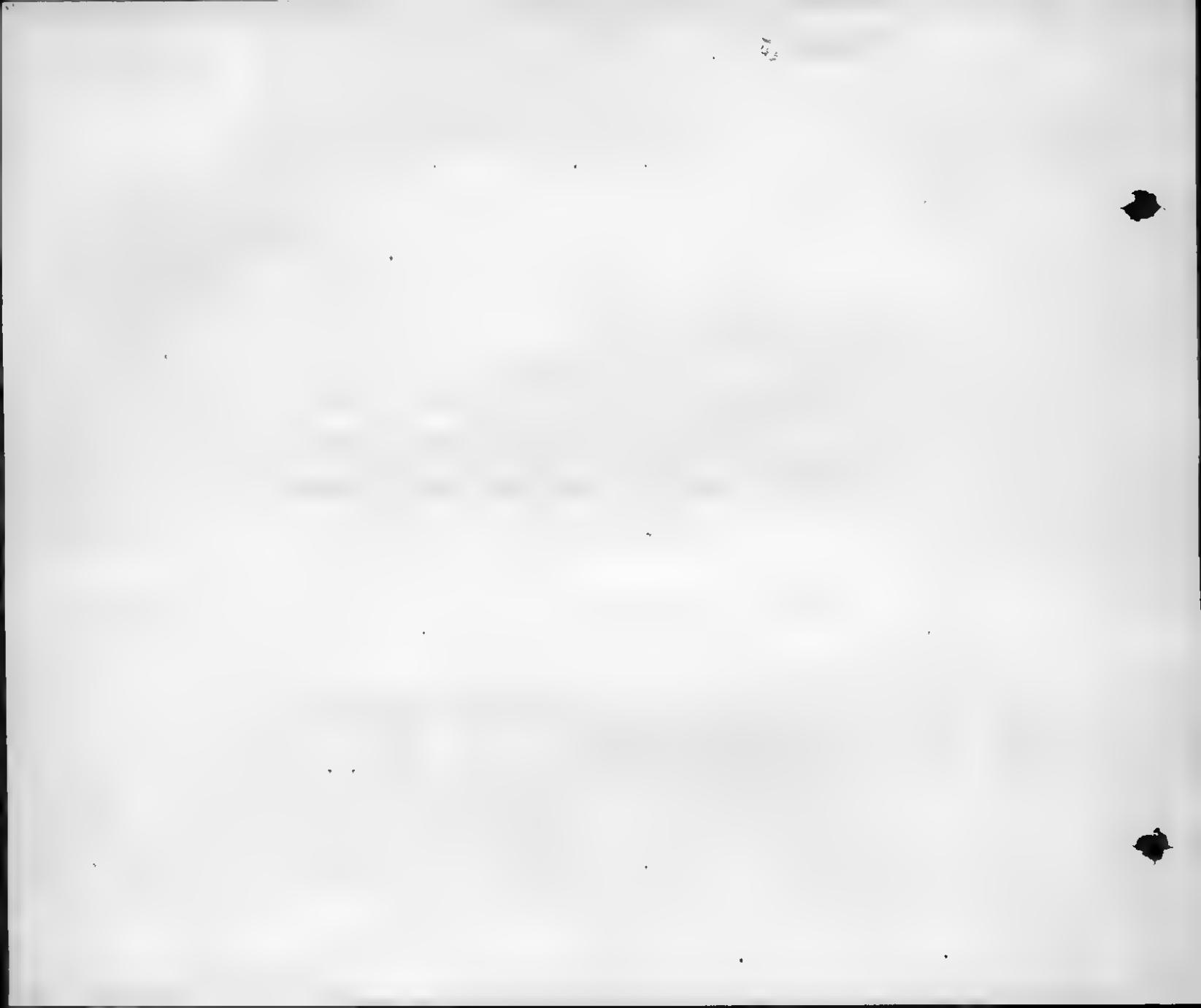
12469

CERTIFICATE OF DEATH

12156

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 yrs. 10 mos. 5 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Balto. City	
3. NAME OF DECEASED (Type or print) Robert		First Robert	Middle James
4. DATE OF DEATH November 20 1961		Last Greenlee Sr.	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 1, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Molder		10b. KIND OF BUSINESS OR INDUSTRY —	
10c. FATHER'S NAME Robert James Greenlee		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. MOTHER'S MAIDEN NAME Sarah Thompson	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		15. SOCIAL SECURITY NO 213-07-6974	
16. INFORMANT Springfield Hospital Records		17. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease			
DUE TO Pulmonary tuberculosis, far advanced.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 20 to 11-20-1961 , that (I) (we) last saw the deceased alive on 11-XI-1961 , and that death occurred at 6:45 a.m. from the causes and on the date stated above			
22a. SIGNATURE <i>Agustin del Campo</i>		M.D. <input type="checkbox"/> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22b. DATE SIGNED 11-20-61
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 22, 1961	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oak Lawn Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		23d. LOCATION (City, town, or county) Baltimore, Maryland	
25a. REC'D BY REGISTRAR DATE NOV 22 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4
 may be recorded by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death Page 5
 (4)
 15M 9/59



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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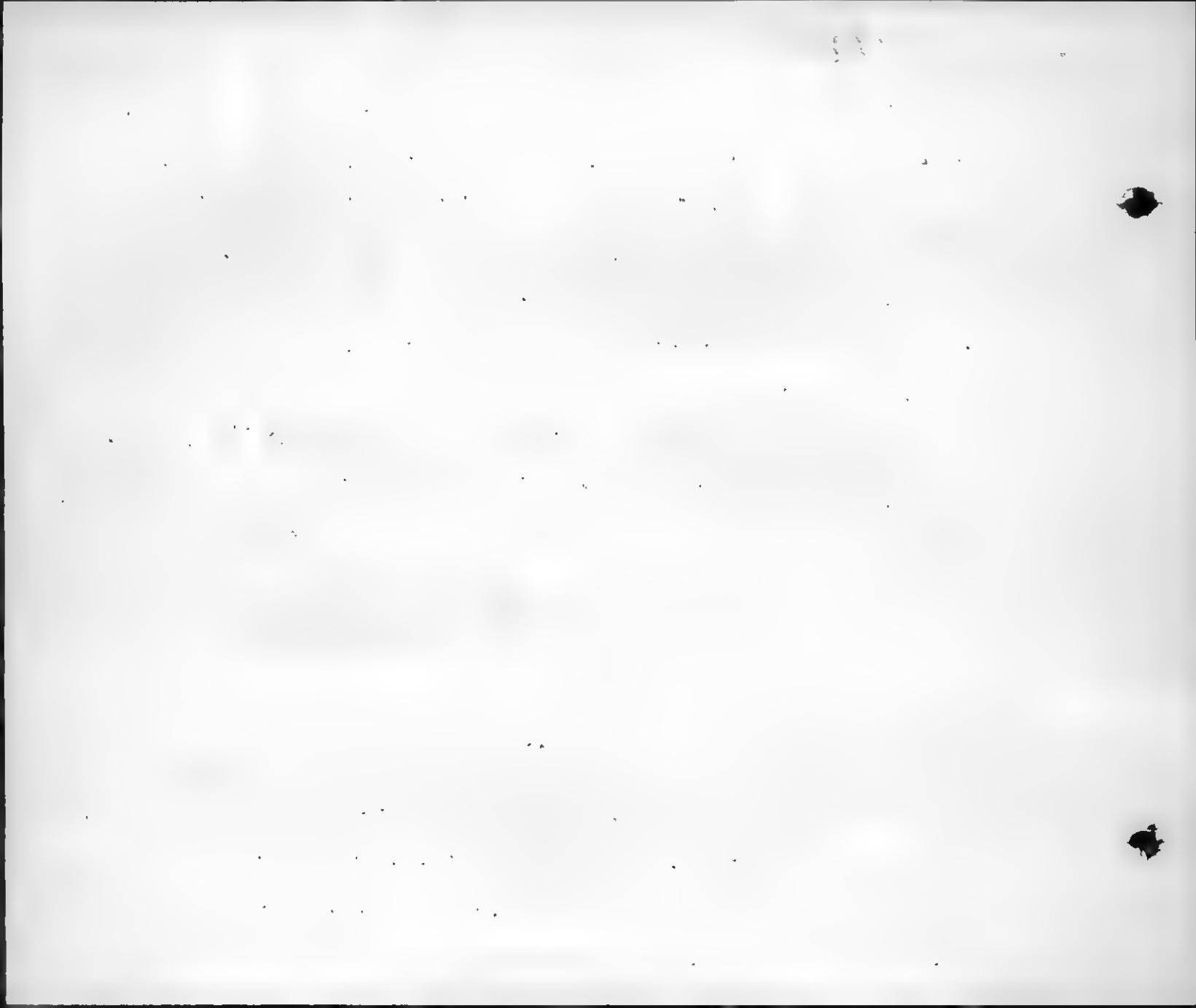
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C

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12470 CERTIFICATE OF DEATH												Reg. Dist. No. 2157
1. PLACE OF DEATH a. COUNTY CARROLL				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				b. COUNTY CARROLL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER				c. LENGTH OF STAY IN 1b 32 YRS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT #5, WESTMINSTER				d. STREET ADDRESS RT #5, WESTMINSTER				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First MARY	Middle MAY	Last HATH		4. DATE OF DEATH NOVEMBER 26 1961	Month NOVEMBER	Day 26	Year 1961			
5. SEX Female		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 31, 1880		9. AGE (In years lost birthday) 81 yrs.	10. IF UNDER 1 YEAR Months 81	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME			11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Wetzel				14. MOTHER'S MAIDEN NAME Unknown								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO NONE			INFORMANT MRS. CLARE STANSBROOK-RT #5, WESTMINSTER, MD.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 10 mos.												
332X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) GENERALIZED ARTERIOSCLEROSIS 44 yrs DUE TO DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JANUARY, 1960 , to NOVEMBER, 1961 , that I last saw the deceased alive on NOV. 25, 1961 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) William L. Stewart, M.D. 19 RIDGE RD DATE SIGNED WESTMINSTER, MD. 11/26/61												
ACTUAL SIGNATURE <i>William L. Stewart</i>		PHYSICIAN'S NAME (Type) William L. Stewart										
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 28, 1961		22c. NAME OF CEMETERY OR CREMATORIAL Keysville Cemetery				22d. LOCATION (City, town, or county) (State) Keysville, Carroll, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Skiles</i>		ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE NOV 28 '61		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>						
VS A15 (4) 15M 9/58												



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be rendered by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12471

12158

1. PLACE OF DEATH o COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE MARYLAND		b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		d. STREET ADDRESS 12 MAIN ST	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12 MAIN ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Nov. 14		Month 1961	Day Year
3. NAME OF DECEASED (Type or print) BERTIE MAY HAINES		First	Middle	Lost	4. DATE OF DEATH Nov. 14	Month 1961	Day Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH APRIL 7-1892	9. AGE (In years last birthday) 69	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS CLOTHING MFG.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY WETZEN		14. MOTHER'S MAIDEN NAME MARY NAILL		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-05-3364		17. INFORMANT HERBERT HAINES		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) UNION BRIDGE	(County) MARYLAND	(State) MARYLAND	22b. DATE SIGNED
21. I certify that (I) (this hospital) attended the deceased from 1961 to 1961 , that (I) (we) last saw the deceased alive on 1961 and that death occurred at 1961 M. from the causes and on the date stated above.		22a. SIGNATURE J. H. MESSLER, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS J. H. MESSLER <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS UNION BRIDGE, MARYLAND		
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/17/61	23c. NAME OF CEMETERY OR CREMATORIAL WINGANORE CEM.	23d. LOCATION (City, town, or county) UNIONVILLE	(State) MARYLAND	25a. REC'D BY REGISTRAR NOV 16 '61	25b. REGISTRAR'S SIGNATURE Caroline L. Thomas
24. FUNERAL DIRECTOR'S SIGNATURE D. H. MESSLER		ADDRESS UNION BRIDGE, MARYLAND					
VR A15 (4) ISM 9/59							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12472

CERTIFICATE OF DEATH

12460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

15

1

2

3

4

1. PLACE OF DEATH
a. COUNTY

Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural—Sykesville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Springfield State Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Ruth

Leeds

5. SEX

6. COLOR OR RACE

Female

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

12/17/83

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Richard H. Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Springfield State Hospital records

Address

Sykesville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

15 IX

Bronchopneumonia

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Carcinoma of the stomach

INTERVAL BETWEEN
ONSET AND DEATH
one day

months

19. WAS AUTOPSY PERFORMED? YES NO

Schizophrenic Reaction, Paranoid Type.

20a. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work Not While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour a.m.

19

p.m.

4/4/1961

11/30/1961

10:20 AM

11/30/1961

21. I certify that (this hospital) attended the deceased from 4/4/1961 to 11/30/1961, that (we) last saw the deceased alive on 11/30/1961, and that death occurred at 10:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Ellis S. Margolin

M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Ellis S. Margolin, M.D.

ATTENDING PHYS.

MED DIRECTOR

STAFF PHYS.

22d. ADDRESS

Springfield State Hospital
Sykesville, Maryland23a. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL
REMOVAL (Specify)

Burial

Dec 6, 1961

Holy Trinity Cemetery

Collington Md

24. FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons Hyattsville Md.

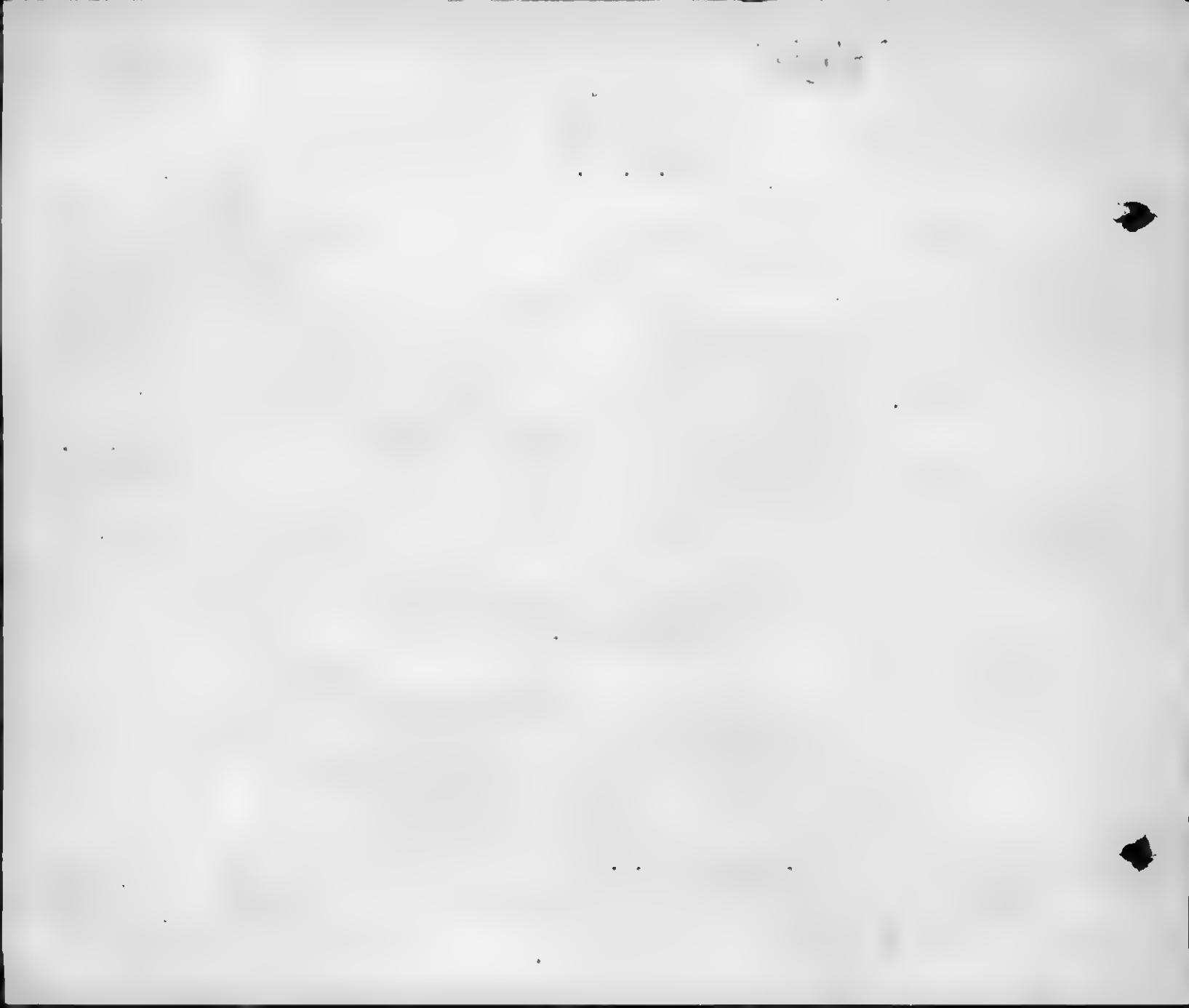
25a. REC'D BY REGISTRAR

DEC 4 '61

25b. REGISTRAR'S SIGNATURE

John S. Krause

VR A15 (4)
15M 7 61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNER DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12473 Items 8 & 9 file u302 1/4/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 161

1. PLACE OF DEATH a. COUNTY <i>Baltimore Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Golden Age Guest Home</i>		d. STREET ADDRESS <i>7002 Queen Anne Road #7</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charlotte Louise Harris</i>		First	Middle
4. DATE OF DEATH <i>November 27 1961</i>		Month	Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 2, 1891</i>
9. AGE (In years lost birthday) <i>69 yrs</i>		10. IF UNDER 1 YEAR Months <i>7</i>	11. IF UNDER 24 HRS. Days <i>25</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Henry Peter Reidt</i>		14. MOTHER'S MAIDEN NAME <i>Amelia Emerick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mrs. Cordelia Reidt-7002 Queen Anne Poad</i>	
17. INFORMANT <i>Mrs. Cordelia Reidt-7002 Queen Anne Poad</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Disease</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Myocarditis</i>			
DUE TO (c) <i>2 yrs</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>✓</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>✓</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. (City or town) <i>✓</i>		(County) (State)	
21. I certify that I attended the deceased from <i>Dec 15, 1961</i> to <i>Dec 27, 1961</i> that I last saw the deceased alive on <i>Dec 27, 1961</i> and that death occurred at <i>11-40 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Horrell H. Martin M.D.</i>		ADDRESS (Street, city or town, state) <i>✓</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>Dykesville, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-30-61</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hopkins & Sons, Baltimore</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 29 '61</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>✓</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

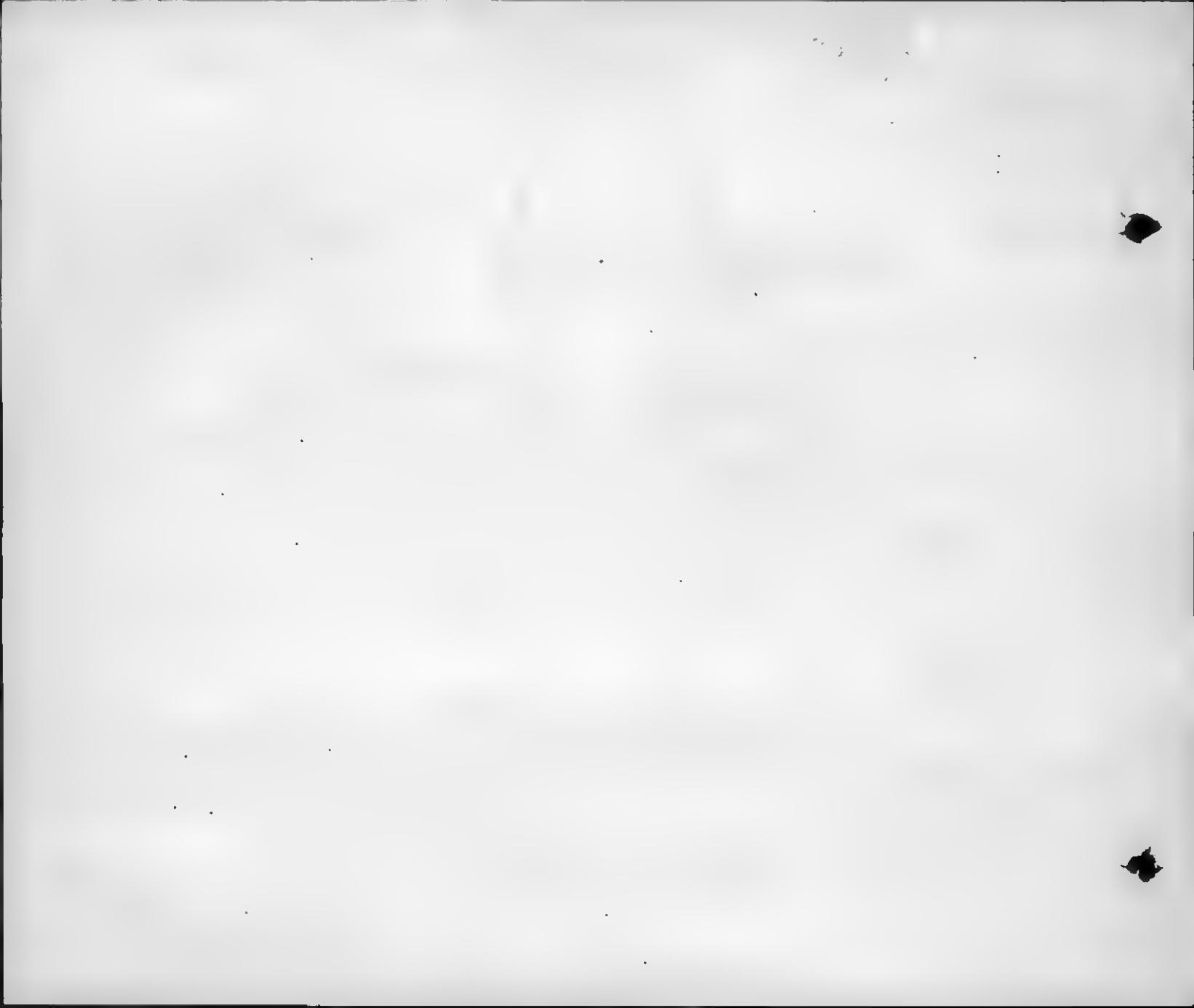
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12475

12163

1. PLACE OF DEATH a. COUNTY	Carroll		Item 2 Film 0302 12/2/61 iwk	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rural - Sykesville		a. STATE	4. LENGTH OF STAY IN 1b	b. COUNTY		
c. LENGTH OF STAY IN 1b	1 year		5. NAME OF HOSPITAL (If not in hospital, give street address or institution)	d. STREET ADDRESS	5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address or institution)	Golden Age Nursing Home		6. STREET ADDRESS	6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	6. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
7. NAME OF DECEASED (Type or print)	First	Middle	7. DATE OF BIRTH	7. AGE (In years last birthday)	7. IF UNDER 1 YEAR IF UNDER 24 HRS.		
8. SEX	Female	White	8. COLOR OR RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. MONTH	8. DAY	8. YEAR
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. DATE OF BIRTH	9. AGE (In years last birthday)	9. IF UNDER 1 YEAR IF UNDER 24 HRS.	9. MONTH	9. DAYS	9. HOURS	9. MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	10c. BIRTHPLACE (State or foreign country)	10d. CITIZEN OF WHAT COUNTRY?				
Housewife	Home	Md.	U.S.A.				
11. FATHER'S NAME	William H. Linton		12. MOTHER'S MAIDEN NAME	Harriett Pickett			
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	14. SOCIAL SECURITY NO.	15. INFORMANT	Address				
No	-	M. Joseph C. Perry - 6105 Birchwood Ave. Balt.					
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular disease</u> INTERVAL BETWEEN ONSET AND DEATH 20 years							
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Advanced Senile Changes</u> years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
19							
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 25, 1961</u> to <u>Nov. 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 25, 1961</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>William H. Linton</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Nov. 26, 1961</u>							
22c. PHYSICIAN'S NAME (Type) <u>William H. Linton, Jr.</u> 22d. ADDRESS <u>Sykesville, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county) (State)		
Burial		11/29/61	Springfield		Sykesville, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>Arthur H. Haight</u>			DATE <u>NOV 30 '61</u>		<u>Charles S. Phenix</u>		



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12164

1. PLACE OF DEATH
a. COUNTY

Carroll

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sykesville

MARYLAND

c. LENGTH OF STAY IN IB
4 mos. 26 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Springfield State Hospital

3. NAME OF
DECEASED
(Type or print)

First
James

Middle

Last
Holden

4. DATE
OF
DEATH

Month
November

Day
8

Year
1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

July 10, 1876

9. AGE (in years
last birth day)

85 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Linotype operator

Canada

U.S.A.

13. FATHER'S NAME

James Holden

14. MOTHER'S MAIDEN NAME

Margaret McMahon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no, or unknown) (If yes give rank, dates of service)

No

215-10-8754

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bronchopneumonia

416 X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Chronic rheumatic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
Chronic brain syndrome with senile brain disease with psychotic reaction

INTERVAL BETWEEN
ONSET AND DEATH

Days

Years

PERFORMED?

YES NO

2. MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While

Not While

at work

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from June 12, 1961, to Nov. 8, 1961, that (I) (we) last saw the deceased alive on November 8, 1961, and that death occurred at 5:10 PM from the causes and on the date stated above.

22e. SIGNATURE

Agustini del Campo

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
11/9/61

22c. PHYSICIAN'S
NAME (Type)

Agustini del Campo, M.D.

22d. ADDRESS

Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

11-12-61

23c. NAME OF CEMETERY OR CREMATORI

New Cathedral Cemetery

23d. LOCATION (City, town or county)

Baltimore, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

John J. Sacksteder

ADDRESS

30 to 17 Ned.

25e. REC'D BY REGISTRAR

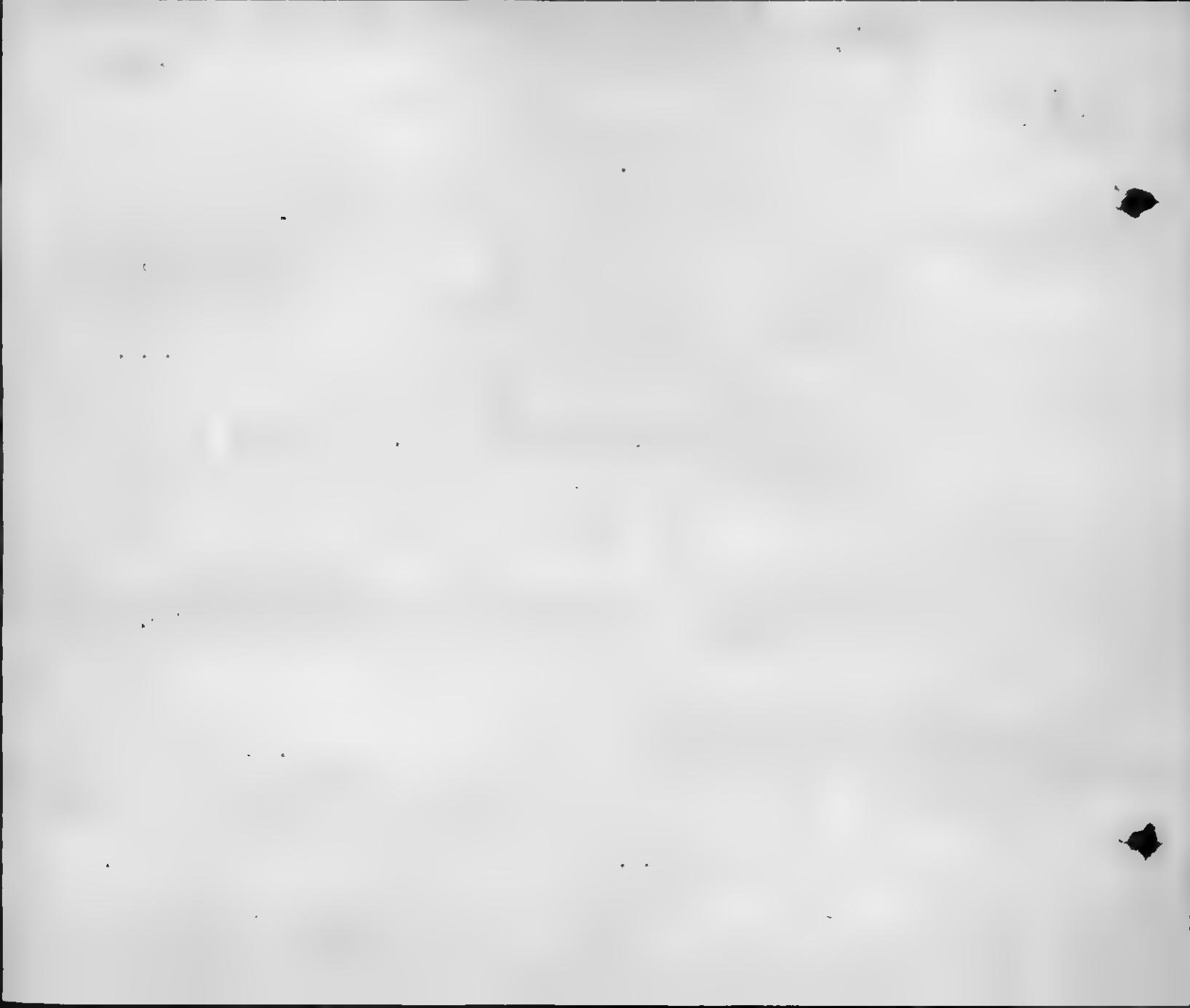
NOV 10 '61

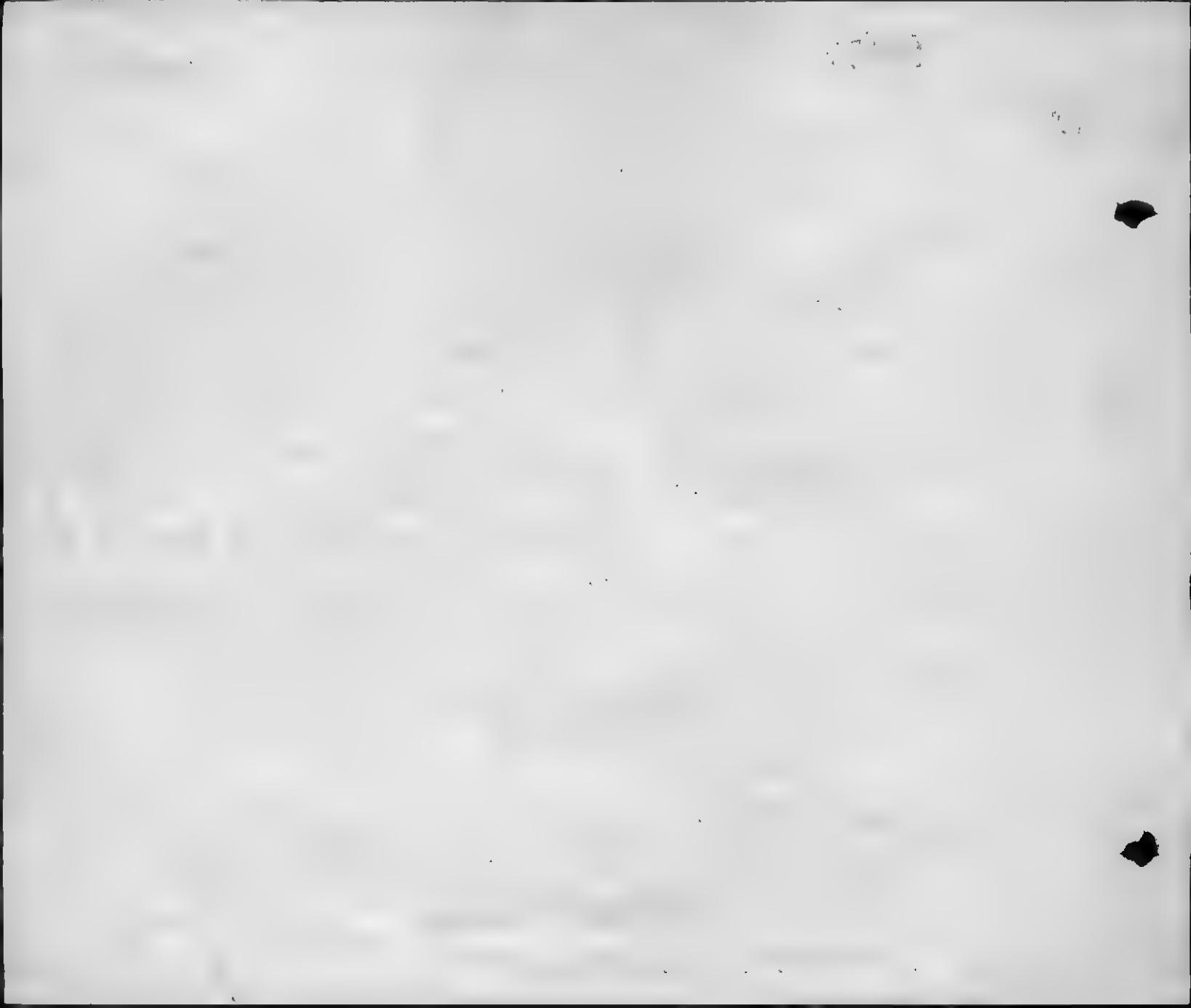
DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Jr.

VR A15 (4)
15M 9/60





TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be read by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the certificate
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

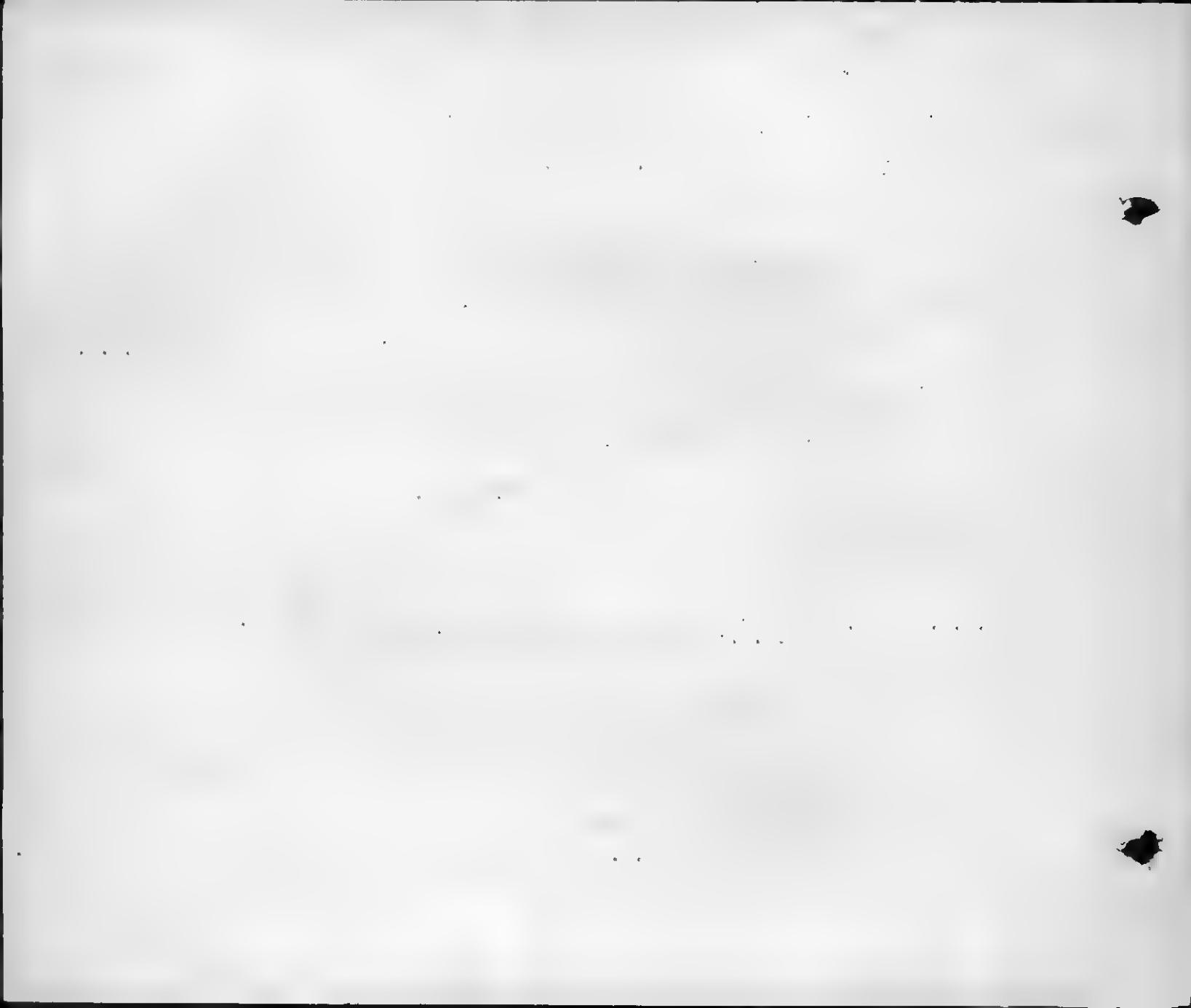
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12478

CERTIFICATE OF DEATH

12166

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Frederick				
c. LENGTH OF STAY IN 1b 1 mo. 12 dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodshoro				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS RT #1				
3. NAME OF DECEASED (Type or print) Samuel		First William	Middle Hough			
Last 		4. DATE OF DEATH November	Month 22			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> July 27, 1891	9. AGE (In years lost birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone crusher operator		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Rodney Hough		14. MOTHER'S MAIDEN NAME Anna Shipman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-3715		17. INFORMANT Springfield Hospital Records		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Acute myocardial infarction.				INTERVAL BETWEEN ONSET AND DEATH Days
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO						
(c) DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with senile brain disease, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-10- 1961 to 11-22- 1961 , that (I) (we) last saw the deceased alive on 11-22- 1961 , and that death occurred at 9 AM , from the causes and on the date stated above.						
22a. SIGNATURE <i>Agustin del Campo</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-22-61		
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV 25-1961		23c. NAME OF CEMETERY OR CREMATORIAL ROCKY HILL		23d. LOCATION (City, town, or county) WOODSBORO (State) MD
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Hartman, Son New Windsor Rd</i>		ADDRESS <i>Gen. Store off New Windsor Rd</i>		25a. REC'D BY REGISTRAR DATE NOV 27 '61		25b. REGISTRAR'S SIGNATURE <i>John S. Price</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12479

CERTIFICATE OF DEATH

12467

1. PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b

6 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Springfield State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Frances Scheeler Ianneo

Month

Dey

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED

DIVORCED

1889

4. DATE
OF
DEATH

November

1

1961

9. AGE (In years
last birthday)

72 yrs

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

Oles Envelope Co

Maryland

14. MOTHER'S MAIDEN NAME

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

Scheeler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Springfield Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

45 Mesenteric thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Days

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Generalized arteriosclerosis

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

C.B.S.

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour

a.m.

p.m.

19

While

Not While

at work

at work

21. I certify that (I) (this hospital) attended the deceased from ... 10-25- 1961 to ... 11-1- 1961, that (I) (we) last
saw the deceased alive on ... 11-1- 1961, and that death occurred at 6:50 a.m. from the causes and on the date stated above.

22e. SIGNATURE

Agustín del Campo

Agustín del Campo, M.D.

M.D. ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
11-1-61

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

11/3/61

23c. NAME OF CEMETERY OR CREMATORI

Holy Redeemer

23d. LOCATION (City, town or county)

Belair Rd., Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Arthur S. Ronan

ADDRESS

3818 Roland Ave

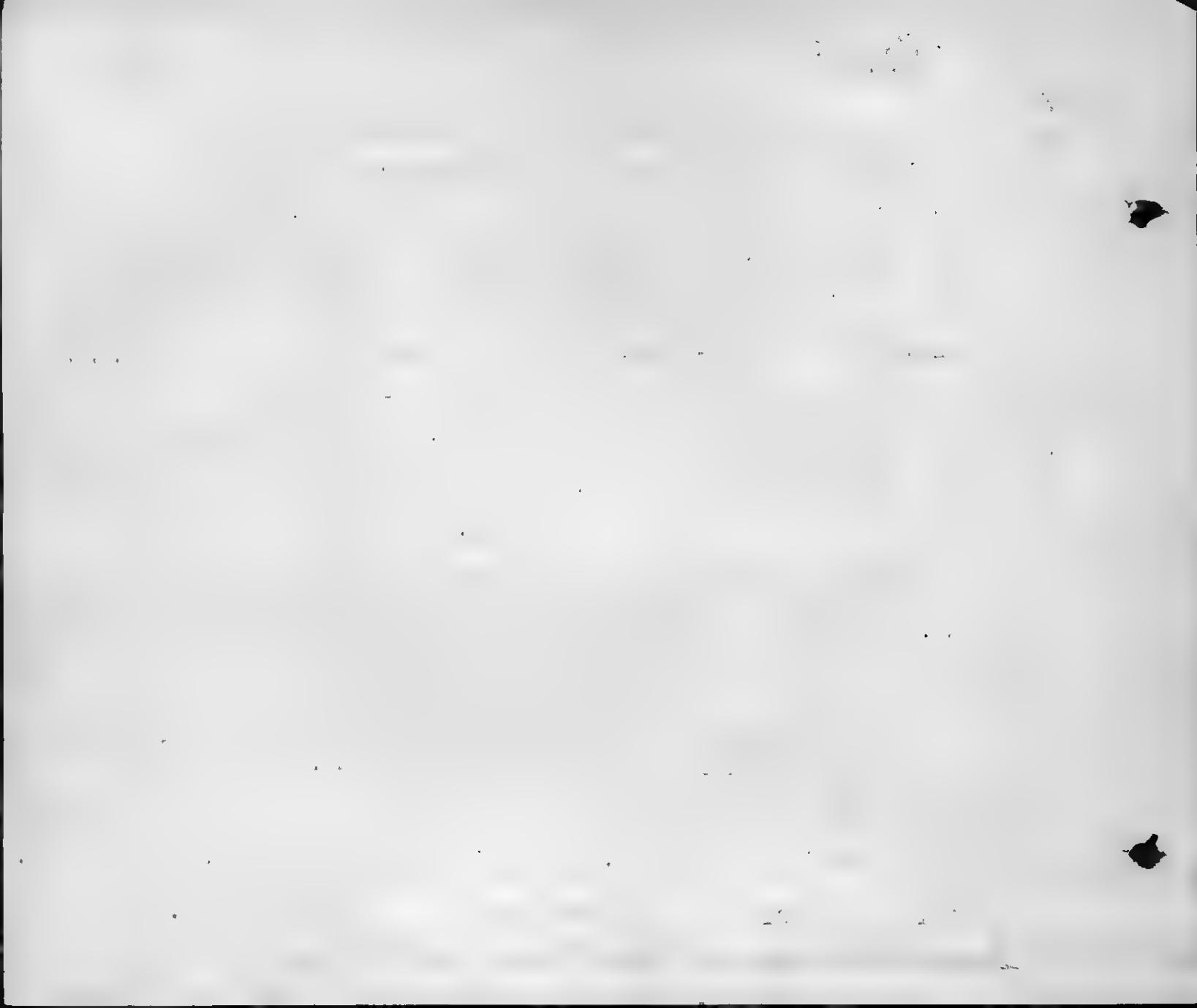
25a. REC'D BY REGISTRAR

NOV 3 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Ronan

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

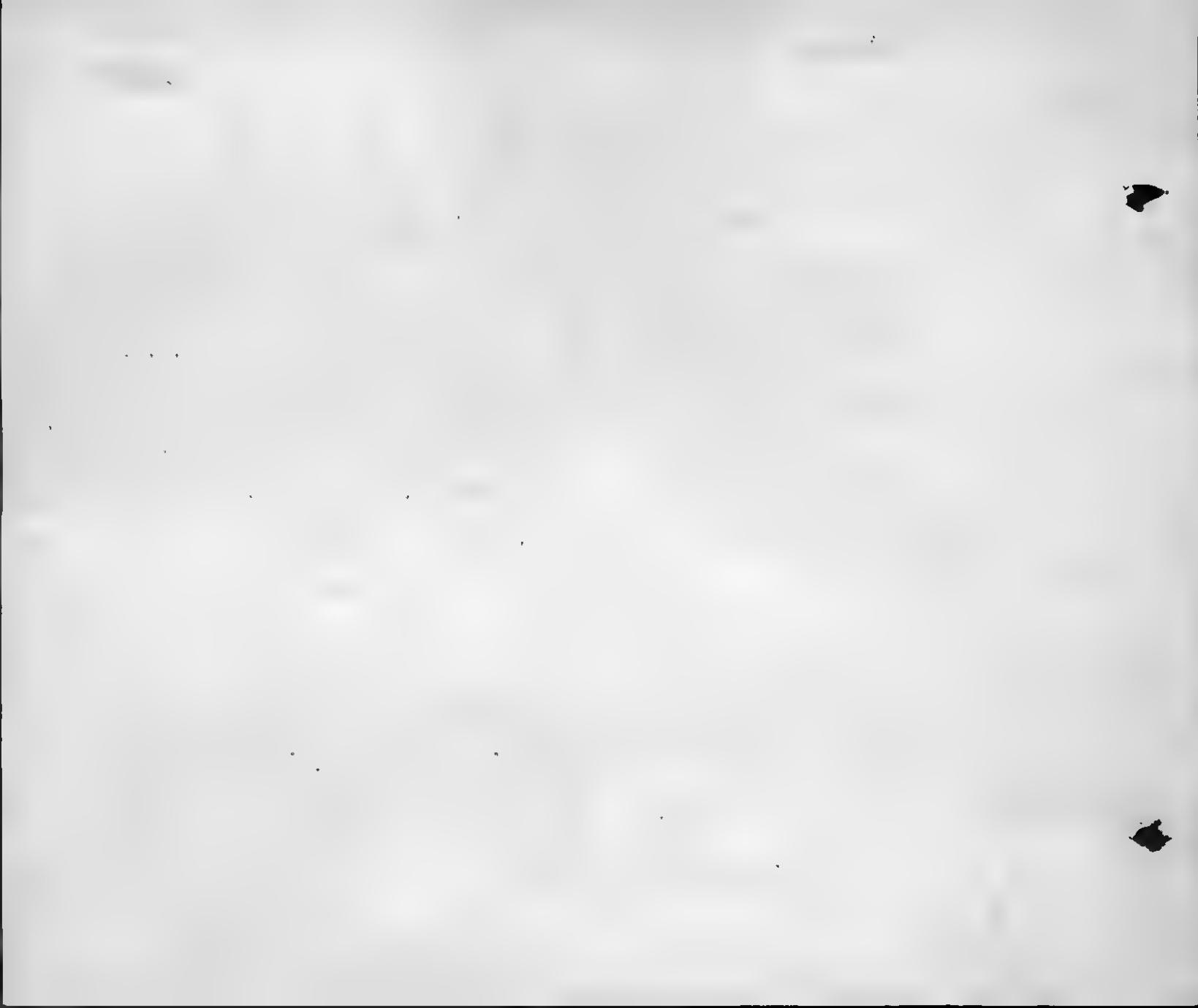
12480

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12468

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Henryton		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 49 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Henryton State Hospital		d. STREET ADDRESS 55 W. Bethel Street	
e. NAME OF DECEASED (Type or print) Bessie		4. DATE OF DEATH Last 27 Month November Day 1961	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 15, 1876		9. AGE (in years last birthday) 85 yrs.	
10a. USWAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State or foreign country) Luray, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Size Dixon		14. MOTHER'S MAIDEN NAME Lena Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Elizabeth Davis 55 W. Bethel St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. X		Cerebro-Vascular Accident. Hemiplegia. Arteriosclerosis.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Minimal bilateral pulmonary tuberculosis.		19. WAS AUTOPSY PERFORMED? X YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 9 1961 to Nov. 27 1961, that (I) (we) last saw the deceased alive on Nov. 27 1961, and that death occurred at 7:15 P.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE Edgars M. Maculans		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans		22d. ADDRESS Henryton State Hospital, Henryton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/61	
23c. NAME OF CEMETERY OR CREMATORIUM Chamney		23d. LOCATION (City, town or county) (State) Burke, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haught		25a. REC'D. BY REGISTRAR DATE NOV 30 '61	
ADDRESS Lykensville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Turner	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12481

CERTIFICATE OF DEATH

12469

1. PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Westminster #3

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Westminster

3. NAME OF
DECEASED
(Type or print)

First

Middle

5. SEX

F

6. COLOR OR RACE

Th

7. MARRIED

 NEVER MARRIED WIDOWED

8. DATE OF BIRTH

 DIVORCED

Last

4. DATE
OF
DEATH

Month

Day

Year

12/16/1879

81

Nov

22

1961

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Hours

Days

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

David Jones

14. MOTHER'S NAME

Eliza Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

None

16. SOCIAL SECURITY NO.

None

17. INFORMANT

None

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

} (c)

Arteriosclerotic changes in coronary arteries

INTERVAL BETWEEN
ONSET AND DEATH

5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

YES NO

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work

Not White at work

at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(City or town)

(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7:30 a.m. to 11:00 p.m. on Nov. 22, 1961, that (I) (we) last saw the deceased alive on Nov. 13, 1961, and that death occurred at 5 p.m. from the causes and on the date stated above.

22a. SIGNATURE

W H Foard

M.D.

ATTENDING PHYS.

 MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

W H Foard M.D.

22d. ADDRESS

41 Winchester Rd

11-24-61

23a. BURIAL, CREMATION, REMOVAL TO FUNERAL DIRECTOR, DATE THEREOF

Carroll 11/25/61

11/25/61

23b. NAME OF CEMETERY OR CREMATORI

Manchester Cemetery

Manchester Rd Carroll

23c. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Frederick Becher & Son

ADDRESS

25a. REC'D BY REGISTRAR

DATE NOV 27 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL: ATTENDING PHYSICIAN: may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

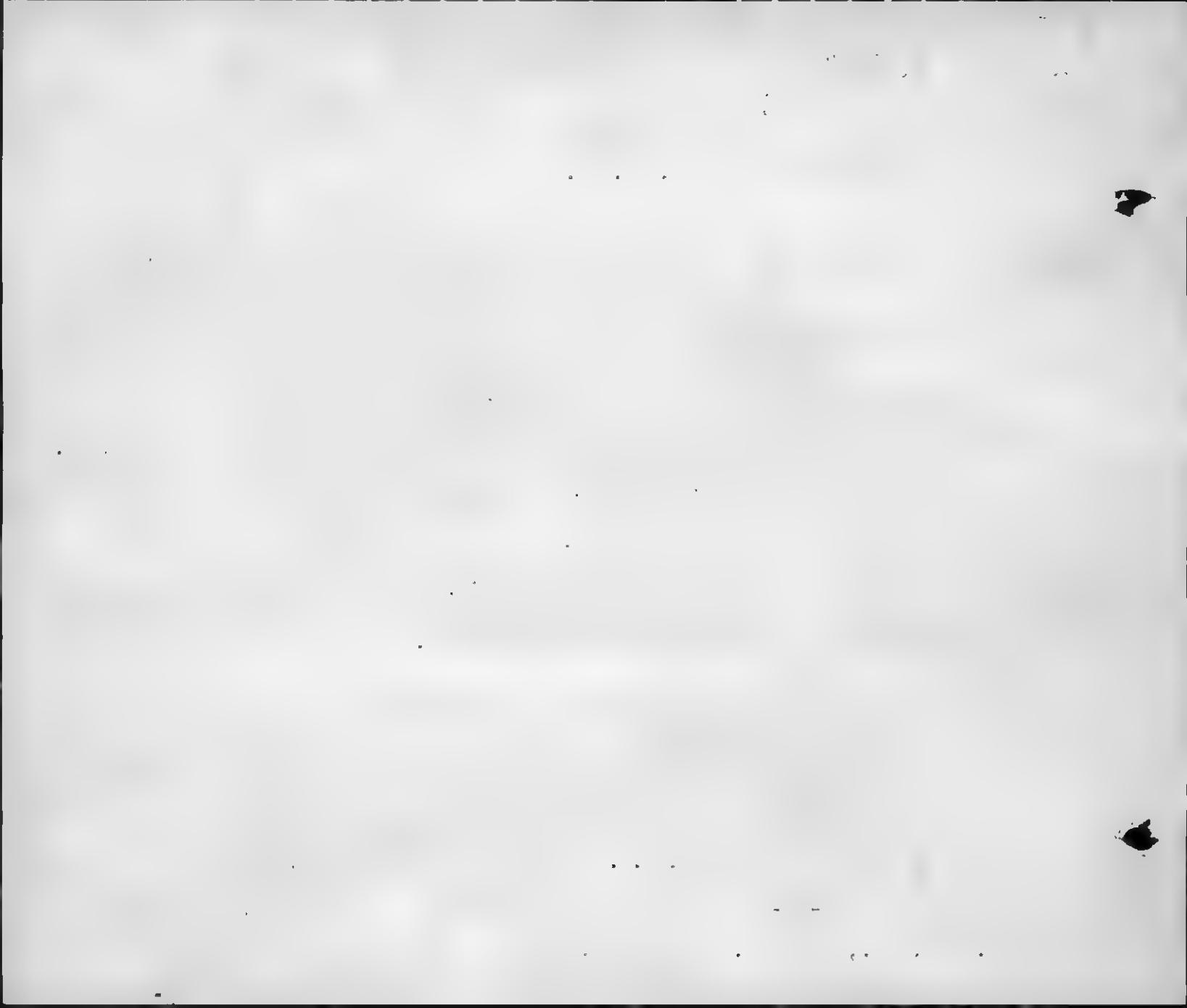
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12482

CERTIFICATE OF DEATH

12471

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville		c. LENGTH OF STAY IN 16 3y. 11m. 15d.		b. STATE Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		f. COUNTY	
15		809 Park Avenue		3/21/74	
3. NAME OF DECEASED (Type or print) Annie		First	Middle	4. DATE OF DEATH 11	Month 28 Dey 1961 Year
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/83	9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) North Carolina	
13. FATHER'S NAME David Snelsen		14. MOTHER'S MAIDEN NAME Harriett Miles		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. none		17. INFORMANT Springfield Hospital records Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Address	
f 2 (c) DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis.				INTERVAL BETWEEN ONSET AND DEATH Years	
[a], stating the underlying cause lost. (c) Bilateral bronchopneumonia.				Years	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		22b. DATE SIGNED 11-28-61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo		M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-30-61	23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cemetery	23d. LOCATION (City, town or county) Elkridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2		ADDRESS	25a. REC'D BY REGISTRAR NOV 29 '61	25b. REGISTRAR'S SIGNATURE Lillian S. Kraus	
VR A15 (4) 15M 7/61					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12483

CERTIFICATE OF DEATH

12172

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b

2mos. 6 dys.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Springfield State Hospital

3. NAME OF DECEASED
(Type or print)

Mary

Louise

Kimmell

4. DATE OF DEATH

313 Arch Street

Month Day Year

November 3, 1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED

8. DATE OF BIRTH

 DIVORCED September 5, 1896

9. AGE (in years last birthday)

65 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Whalley

14. MOTHER'S MAIDEN NAME

Mary P. Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Springfield Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Infected bed sore and malnutrition, severe.

Late Latent Syphilis.

INTERVAL BETWEEN
ONSET AND DEATH

Months

Years

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

C.B.S. associated with C.N.S.; Syphilis with psychotic reaction

20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED

While
at work Not While
at work 20a. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

8-24-1961 to 11-3-1961

that (I) (we) last saw the deceased alive on 11-3-1961, and that death occurred at 5:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Agustín del Campo M.D.

22b. DATE
SIGNED

11-3-61

22c. PHYSICIAN'S
NAME (Type)

Agustín del Campo, M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

NOV 8 '61

C. L. S. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If age 4 or less, retain by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MR. A15 (4)
15H 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [Page 4 may be retained by the hospital or attending physician.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
1SM 9/60

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Funetone</i>		c. LENGTH OF STAY IN 1b <i>30 days</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X-Funetone</i>		
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>FLORENCE</i>		First <i>S</i>	Middle <i>KELLER</i>	
4. DATE OF DEATH <i>Nov 29 1961</i>		Last <i>S</i>	Month <i>Nov</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>1/14/1899</i>		9. AGE (In years last birthday) <i>62 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>19212-32-4782</i>		
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Theo. R. Streng</i>		14. MOTHER'S MAIDEN NAME <i>Susan Geller</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES, NO, or UNKNOWN <i>No</i>		16. SOCIAL SECURITY NO. <i>19212-32-4782</i>		
17. INFORMANT <i>Maurice Kellner</i>		Address <i>Funetone</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Astrographic Sarcoma Paget Disease Arteritis Deformans 5 yrs		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that (I) this hospital attended the deceased from <i>Sept. 1948</i> to <i>Nov. 29, 1961</i> , that (I) (we) last saw the deceased alive on <i>Nov. 28, 1961</i> , and that death occurred at <i>631 N. W.</i> from the causes and on the date stated above.				22b. DATE SIGNED
22a. SIGNATURE <i>W H Foard</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>W H Foard M.P.</i>		22d. ADDRESS <i>Manchester, Md</i>		22b. DATE SIGNED <i>11-29-61</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/1/61</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Funetone</i>	23d. LOCATION (City, town or county) <i>Funetone</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>W H Foard</i>		ADDRESS <i>Glen Rock Rd</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 5 '61</i>	25b. REGISTRAR'S SIGNATURE <i>John S. Trahan</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

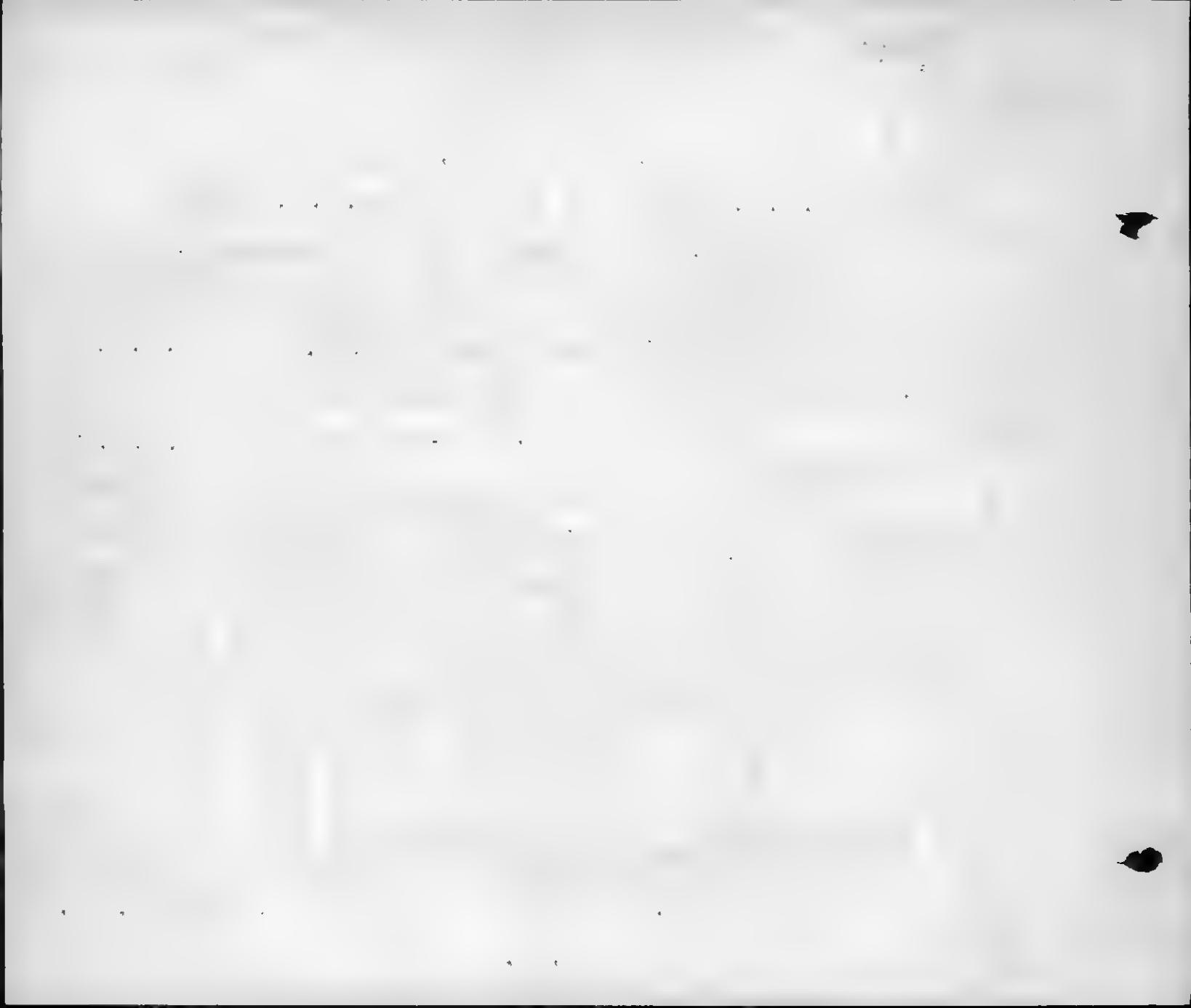
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12485

12471

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. LENGTH OF STAY IN 1b 37 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 1 (Silver Run)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster	
3. NAME OF DECEASED (Type or print) Roy D. Knouse		First D.	Middle Knouse
4. DATE OF DEATH November 14, 1961		Month November	Day 14
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/1884
9. AGE (In years from last birthday) 77	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Canner	10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	11. BIRTHPLACE (State or foreign country) Adams County, Pa.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Isaiah D. Knouse		14. MOTHER'S MAIDEN NAME Agnes Hartman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-03-9089	17. INFORMANT Mrs. Rhea Knouse, Westminster, Md. R. D. 1
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 37x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 15 years 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/13/1961 to 11/14/1961, that (I) (we) last saw the deceased alive on 11/14/1961, and that death occurred at M. from the causes and on the date stated above.		22b. DATE SIGNED 11/15/61	
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Tannaytown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/17/61	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	23d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.
24. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little	ADDRESS Littlestown, Pa.	25a. REC'D BY REGISTRAR NOV 16 '61	25b. REGISTRAR'S SIGNATURE R. S. Knouse



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12486

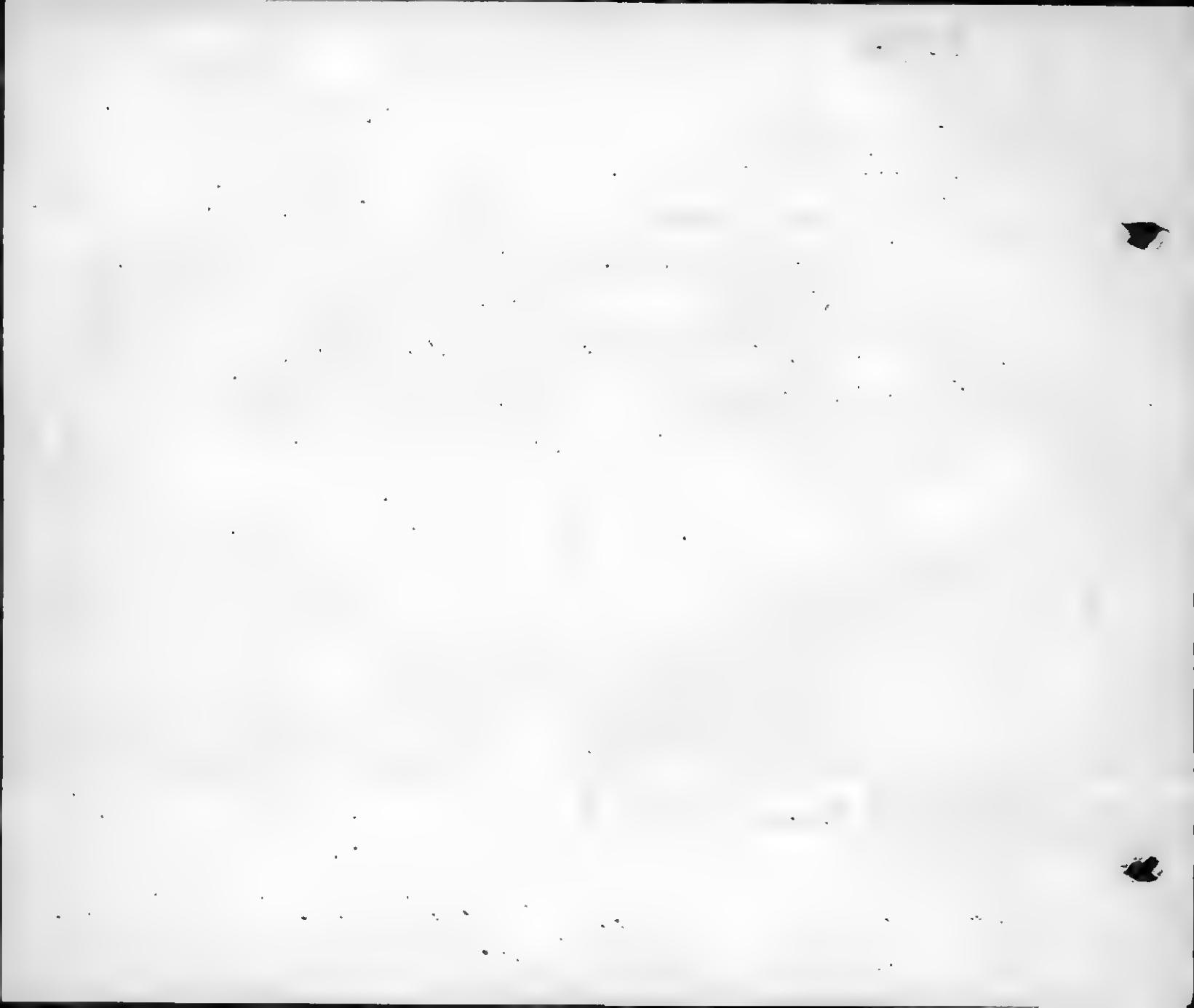
CERTIFICATE OF DEATH

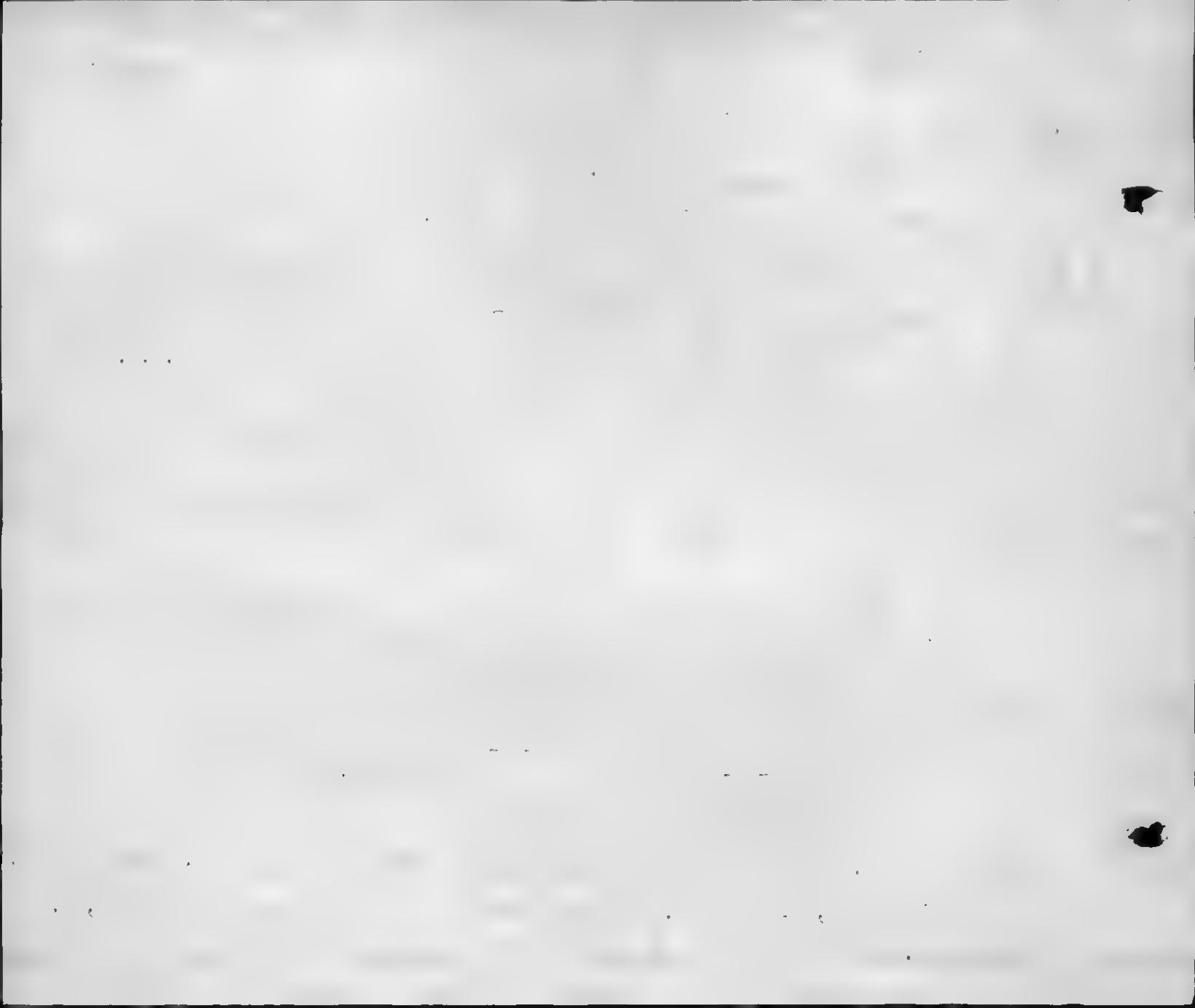
12486 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Carroll Co.		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Jenkintown Rd.		12 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Deer Park Road		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) GEORGE		First	Middle
		Anthony	KROEN
4. DATE OF DEATH		Month NOV.	Day 29
		Year 1961	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		white	8. DATE OF BIRTH
			July 15, 1892
9. AGE (In years from last birthday)		10. IF UNDER 1 YEAR IF UNDER 24 MRS	
69 yrs		Months 6	
		Days 29	
		Hours 0	
		Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Shopkeeper, Md. Drydock Co.		Baltimore Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Charles Kroen		Theresa Deppisch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	INFORMANT
		212-07-9807	Mrs Geo A. Kroen, Same address
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		3 MIN.	
DUE TO (b) DUE TO (c)		GENERAL HEMORRHAGE	
GENERALIZED ARTERIOSCLEROSIS		24 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from AUGUST 1959, to NOVEMBER 29 1961, that I last saw the deceased alive on OCTOBER 1, 1961, and that death occurred at 1:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
William L. Stewart, M.D.		19 RIDGE RD WESTMINSTER, MD. 11/29/61	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS
Burial		12/2/61	Greenwood Memorial Gardens, Jenkintown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
J. S. Myers Jr., Westminster, Md.		DATE DEC 4 '61	Clifford S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12477

12488

1. PLACE OF DEATH

2. COUNTY

Carroll

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sykesville

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Springfield State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

John

Herbert

McGowan

4. SEX

Male

5. COLOR OR RACE

White

6. MARRIED

NEVER MARRIED WIDOWED DIVORCED

7. MARRIED

NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

April 29, 1884

9. AGE (In years
last birthday)

77 yrs.

Last

4

DATE
OF
DEATH

Month

Month

Day

Day

Year

Year

November

28,

1961

Hours

19

Min.

60

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Night watchman

10b. KIND OF BUSINESS OR INDUSTRY

Yards

11. BIRTHPLACE (County & State, or foreign country)

North Carolina

13. FATHER'S NAME

Henry McGowan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Springfield Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Bronchopneumonia

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause least. } DUE TO

} (b) _____

} DUE TO

} (c) _____

INTERVAL BETWEEN
ONSET AND DEATH

Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AN AUTOPSY

INVOLUNTIONAL PSYCHOTIC REACTION. Fracture, neck of left femur.
(Dr. Marsh, Medical Examiner, notified but did not accept jurisdiction.) YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour a.m. While at work Not While at work p.m. While at work Not While at work

20f. (City or town) Sykesville Carroll Md.

10/27/61

(County) Carroll

(State) Md.

21. I certify that (I) (this hospital) attended the deceased from

20f. (City or town) Sept. 9, 1955 to November 28, 1961,

(County) Carroll (State) Md.

saw the deceased alive on November 28, 1961, and that death occurred at 9:35PM

20f. (City or town) from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE

22c. PHYSICIAN'S NAME (Type)

SIGNED

11/29/61

Agustín del Campo, M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

22d. ADDRESS

Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, 23b. DATE THEREOF

23c. NAME OF CEMETERY OR Crematory

23d. LOCATION (City, town or county)

(State)

REMOVAL (Specify)

Burial 12-1-61

23a. REC'D BY REGISTRAR

23b. REGISTRAR'S SIGNATURE

11/29/61

Cremation

DATE

NOV 30 '61

C. L. Kline

Death

11/29/61

Burial

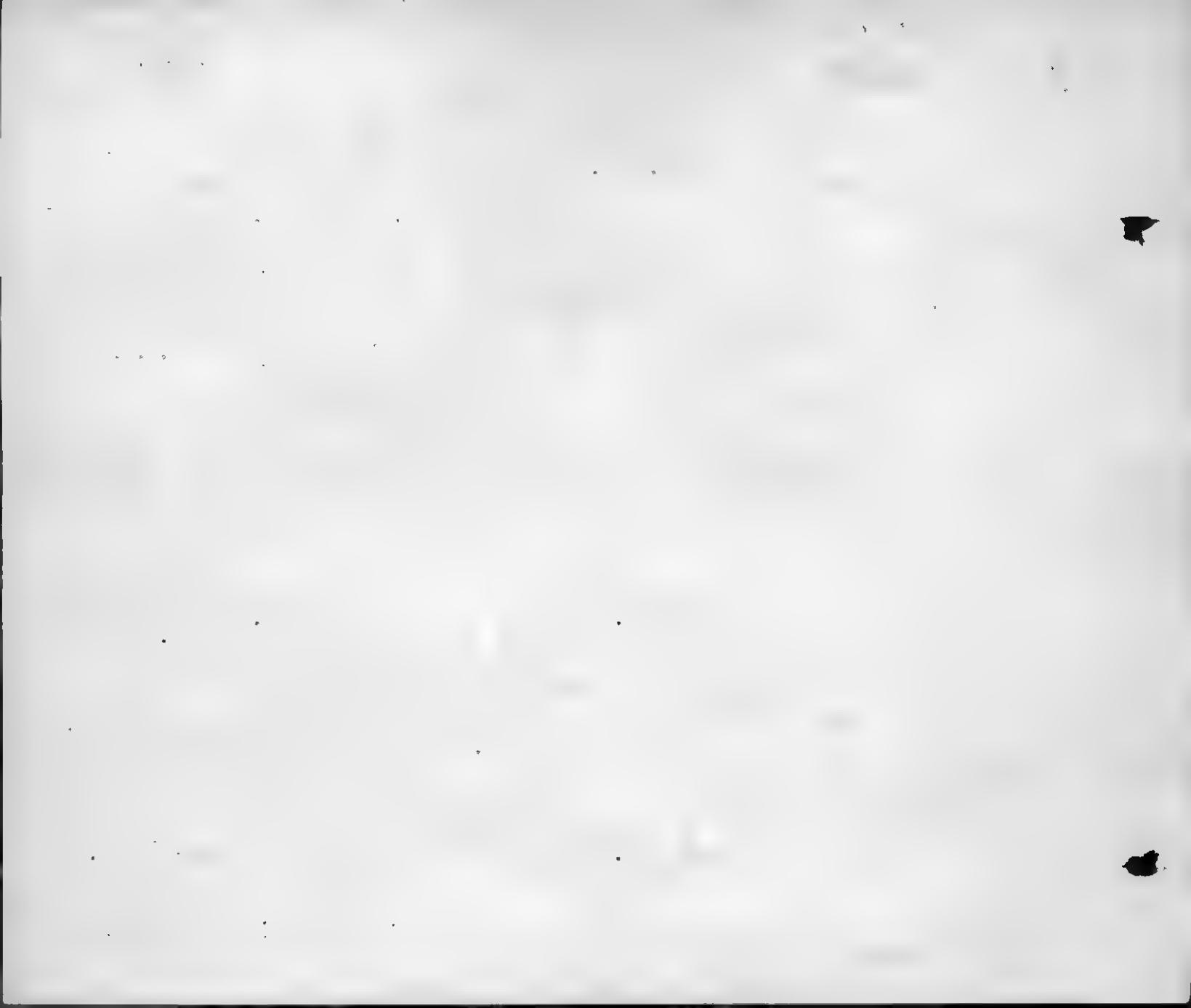
11/29/61

Cremation

11/29/61

Burial

11/29/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be rendered by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12489

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12178

1. PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville Rd #3

c. LENGTH OF STAY IN 1b

76 years

d. NAME OF HOSPITAL (If not in hospital, give street address)

ORGANIZATION

London Bridge Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville Rd #5

d. STREET ADDRESS

London Bridge Road

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First Middle Last

GEORGE HERSCHEL MILLER

4. DATE
OF
DEATH

Month Day Year

NOV. 22 1961

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

76

10. RESIDENCE
11. IF UNDER 1 YEAR
12. IF UNDER 24 HRS

Months

Days

Hours

Min.

Male white

WIDOWED DIVORCED

30. JEWISH OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

farmer

self employed Carroll Co. Md.

U.S.A.

13. FATHER'S NAME

Thomas J. Miller

14. MOTHER'S MAIDEN NAME

Harriet Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)
(If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. G. Herschel Miller, address same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Arteriosclerosis, cardio-thoracic disease

INTERVAL BETWEEN
ONSET AND DEATH

years

422.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Bronechitis

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.

20d. INJURY OCCURRED
While Not while
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Sept 19, 1960, to Nov 22, 1961, that (I) (we) last
saw the deceased alive on Nov 21, 1961, and that death occurred at 8P.M., from the causes and on the date stated above.

22a. SIGNATURE

James T. Marsh

M.D.

ATTENDING PHYS

X

MED.

DIRECTOR

STAFF

PHYS

22b. DATE
SIGNED
11-23-61

22c. PHYSICIAN'S
NAME (Type)

JAMES T. MARSH

22d. ADDRESS

Westminster

Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

11/25/61

23c. NAME OF CEMETERY OR CREMATORI

Providence Cemetery

23d. LOCATION (City, town, or county)

Carroll Co. Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

J. E. Myers, Jr. Westminster, Md.

ADDRESS

Westminster

25a. REC'D BY REGISTRAR

Nov 30 '61

DATE

11-23-61

REGISTRAR'S SIGNATURE

Elmer S. Krause



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
12470 STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12479

1. PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b

30 yrs. 6 mos. 8 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Springfield State Hospital

3. NAME OF

First
(Type or print)

Vincent

Middle

Munschow

Parkville

4. DATE
OF
DEATH

Last

None

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

September 6, 1908

9. AGE (In years
less birthday)

53

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

Frank Munschow

14. MOTHER'S MAIDEN NAME

Elizabeth Senft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Address
Springfield Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Asphyxia due to occlusion of trachea with food.

INTERVAL BETWEEN
ONSET AND DEATH

Minutes.

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Epilepsy with mental deficiency.

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

11/13/61

22a. BURIAL, CREMATION
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

11-16-61

22c. NAME OF CEMETERY OR GREA
TORY

New Cathedral Cemetery

22d. LOCATION (City, town, or country) (State)

Baltimore, Md.

23. FUNERAL DIRECTOR

Arthur H. Wright

ADDRESS

Sykesville, Md.

24a. REC'D BY REGISTRAR

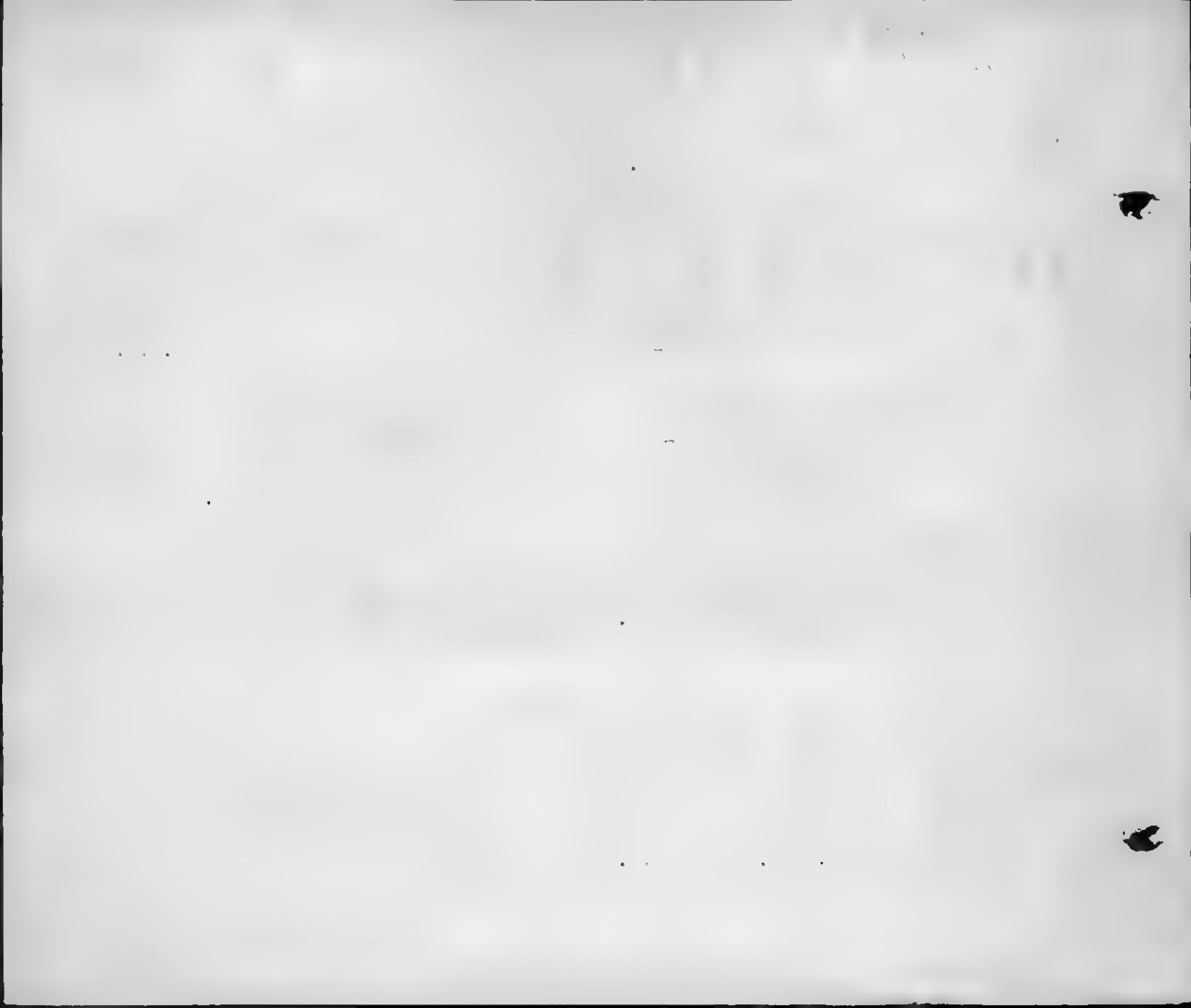
DATE NOV 20 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Trahan

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12491

12490

1. PLACE OF DEATH

a. COUNTY
Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

(Rural) Sykesville

c. LENGTH OF STAY IN lb

3y. 3m. 2d.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Springfield State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Brendan

Michael

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

 NEVER MARRIED

8. DATE OF BIRTH

6-2-1892

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

10b. KIND OF BUSINESS OR INDUSTRY

--

11. BIRTHPLACE (County & State, or foreign country)

USA

13. FATHER'S NAME

Michael J. O'Brien

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

yes W.W. I

16. SOCIAL SECURITY NO.

17. INFORMANT

217-16-7191

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)31X
DUE TOConditions, if any, which
gave rise to immediate cause
(a), stating the underlying
as: (b)

Cerebral Vascular Accident

DUE TO

Arteriosclerosis gener.
(c)PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I.a) 19. WAS AUTOPSY
Chronic brain syndrome associated with cerebral arteriosclerosis with
psychotic reaction. PERFORMED?
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)YES NO

MEDICAL CERTIFICATION

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that (I) (this hospital) attended the deceased from 11/18/1958, 1961, to 11-7-1961, that (I) (we) last
saw the deceased alive on 11-7-1961, and that death occurred 4:45 P.M. from the causes and on the date stated above

22a. SIGNATURE

Myron Nizankowsky, M.D.

22b. DATE
SIGNED
11-7-6122c. PHYSICIAN'S
NAME (Type)ATTENDING
PHYS.
M.D. MED.
DIRECTOR
STAFF
PHYS.

22d. ADDRESS

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial 11/10/61

23b. DATE THEREOF

Cathedral Cemetery

23d. LOCATION (City, town or county)

Balto, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

WIEDEFELD & SON

25a. REC'D BY REGISTRAR

NOV 9 '61

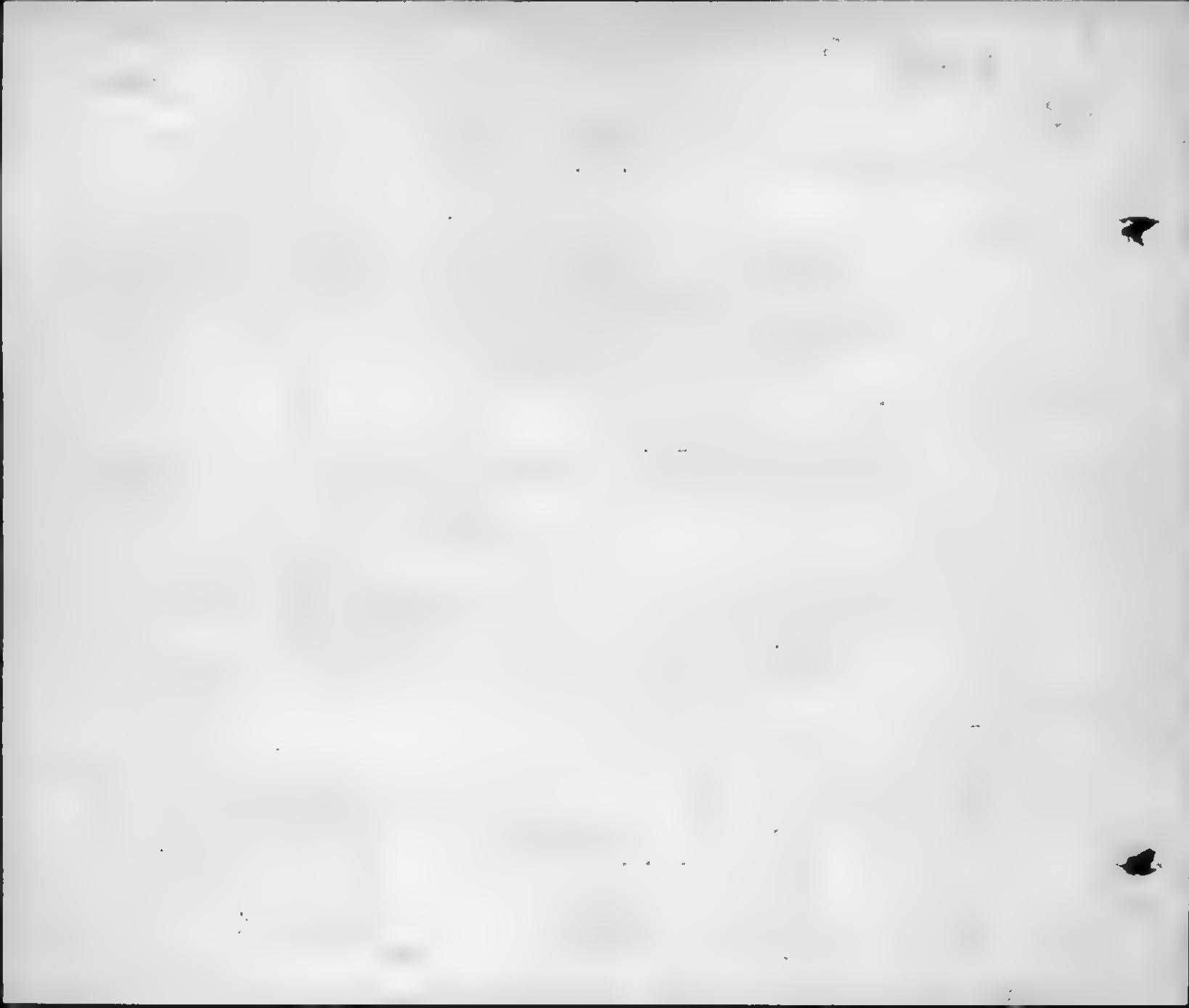
25b. REGISTRAR'S SIGNATURE

John S. Hause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION 12432 STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

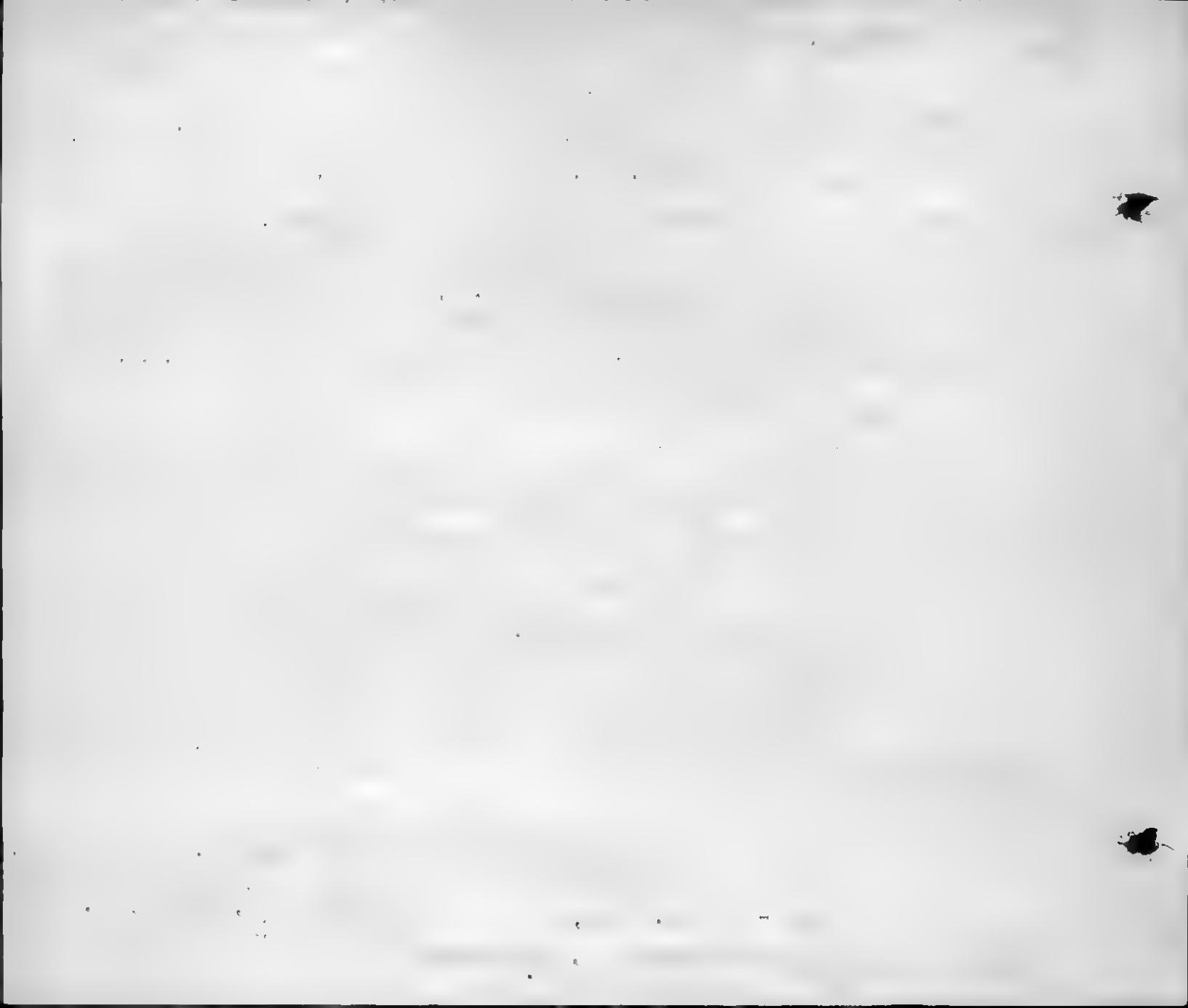
CERTIFICATE OF DEATH

12181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours are required, the physician or attending physician, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M
15
I

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>Baltimore</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN lb <u>39 yrs. 4 mos.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		f. STREET ADDRESS <u>1513 Battery Avenue</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Caroline</u>		4. DATE OF DEATH <u>Nov. 27, 1961</u>		5. AGE (In years IF UNDER 1 YEAR last birthday) <u>70 yrs.</u>		6. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
7. SEX <u>Female</u> COLOR OR RACE <u>White</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>Sept. 6, 1891</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. MOTHER'S MAIDEN NAME <u>Mary Glenzer</u>	
13. FATHER'S NAME <u>John Euler</u>		14. INFORMANT <u>Springfield Hospital Records</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u>	
17. PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
DUE TO <u>4/20/0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Arteriosclerotic heart disease</u>		DUE TO <u>Arteriosclerosis</u>		21. I certify that (I) (This hospital) attended the deceased from <u>7-27-61</u> to <u>11-27-61</u> , that (I) (we) last saw the deceased alive on <u>11-27-61</u> , and that death occurred at <u>2:30 P.M.</u> From the causes and on the date stated above.	
22. MEDICAL CERTIFICATION		23. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) <u>20f. (City or town)</u> (County) <u>20g. (County)</u> (State) <u>20h. (State)</u>	
26. SIGNATURE <u>Agustin del Campo.</u>		27. ATTENDING PHYS. <input type="checkbox"/> M.D. <u>Agustin del Campo, M.D.</u>		28. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		29. DATE SIGNED <u>11-27-61</u>	
30. PHYSICIAN'S NAME (Type) <u>Agustin del Campo</u>		31. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>		32. LOCATION (City, town or county) <u>Randallstown, Balto co., Md.</u>		(State) <u>Md.</u>	
33. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		34. DATE THEREOF <u>11-29-1961</u>		35. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Mt. Olive,</u>		36. LOCATION (City, town or county) <u>Randallstown, Balto co., Md.</u>	
37. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Byers</u>		38. ADDRESS <u>8728 Liberty Rd., Randallstown</u>		39. DATE <u>DEC 4 '61</u>		40. REG'D BY REGISTRAR <u>Arthur L. Hause</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12493

CERTIFICATE OF DEATH

12482

1. PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b

2 Mos.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Springfield State Hospital

3. NAME OF
DECEASED
(Type or print)

Woldemar

First

Middle

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED 10a. JESTAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None x Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Book Firm

8. DATE OF BIRTH

4-30-93

Prii

Lesi

4. DATE
OF
DEATH 11-23-61 19

Month

Day

Year

9. AGE (in years) IF UNDER 1 YEAR

IF UNDER 24 HRS.
last birthday Months Days Hours Min.

68 yrs.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ferdinand Prii

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or date of service

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

No

Unknown

Springfield State Hospital

Sykesville, Md.

INTERVAL BETWEEN
ONSET AND DEATH
Days

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bilateral Pneumonia

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

Parkinson's Disease

Chronic Brain Syndrome associated with cerebral arteriosclerosis

20e. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

20d. INJURY OCCURRED

p.m.

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 10-20-61

19

to 11-23-61

19

, that (I) (we) last
saw the deceased alive on 11-23-61 19 , and that death occurred at 5A.M. from the causes and on the date stated above.

22a. SIGNATURE

J. Radzykewycz

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED
11-23-6122c. PHYSICIAN'S
NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

Burial

11/25/61

Parklawn Cemetery

Rockville, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Robert A. Pumphrey Funeral Home Beth. Md.

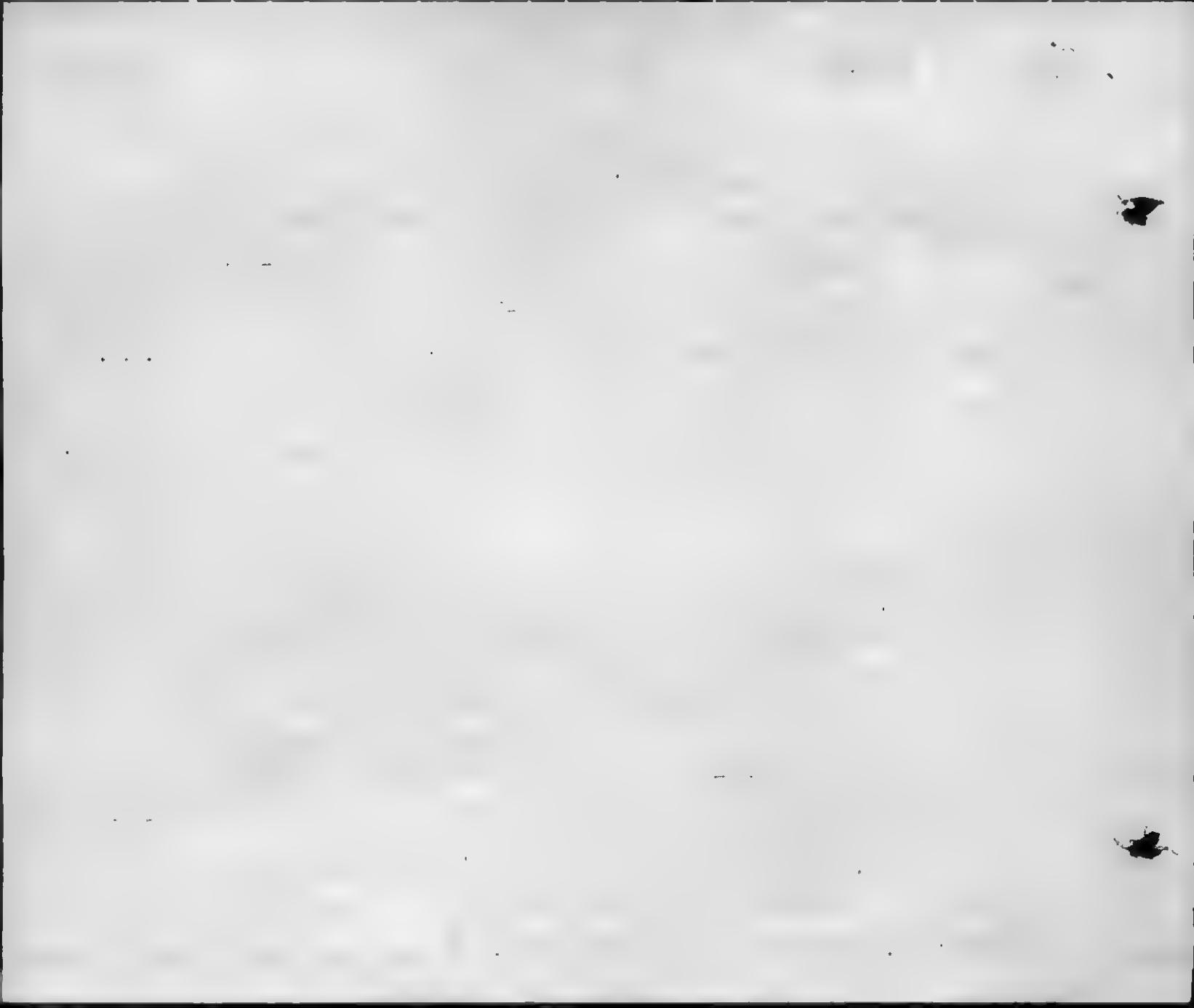
DATE NOV 30 '61

Signature

TO HOSPITAL OR MEDICAL PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, send in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

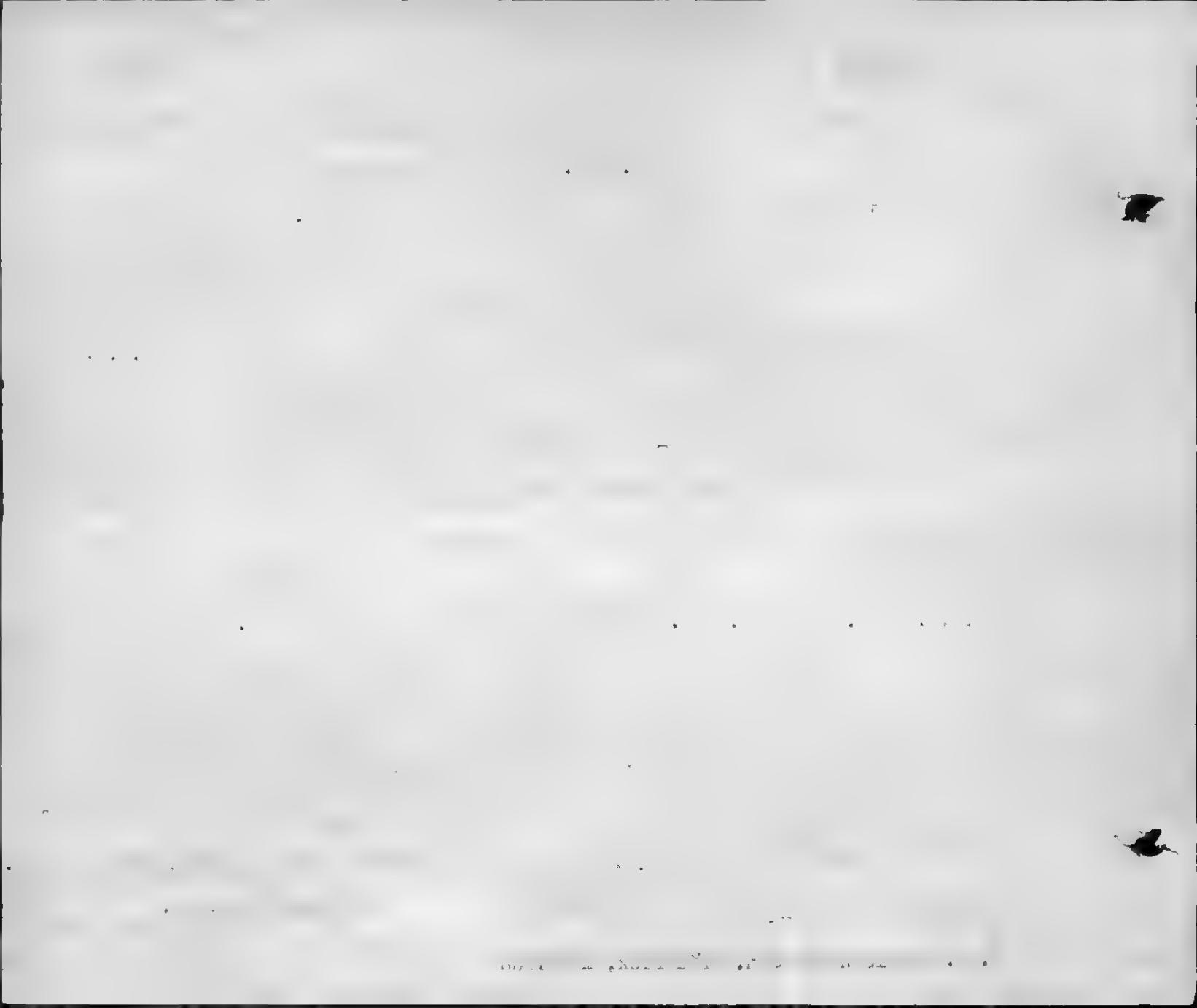
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12494

CERTIFICATE OF DEATH

12183

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6yrs. 7mos. 4days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) John William Rice		d. STREET ADDRESS 316 Park Ave.	
4. DATE OF DEATH November 9, 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		f. COLOR OR RACE White	
6. MARRIED WIDOWED		7. NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH October 10, 1875		9. AGE (In years last birthday) 86 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Jacob Daniel Rice		14. MOTHER'S MAIDEN NAME Katherine Wachter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease			
DUE TO Generalized arteriosclerosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO Generalized arteriosclerosis			
DUE TO Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with circ. dist. other than cerebral arteriosclerosis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 5, 1960 to November 9, 1961 that (I) (we) last saw the deceased alive on November 8, 1961 , and that death occurred at 1:00AM from the causes and on the date stated above.			
22e. SIGNATURE Agustin del Campo		22b. DATE SIGNED 11/9/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-11-1961	
23c. NAME OF CEMETERY OR CREMATORIAL Utica Cemetery		23d. LOCATION (City, town or county) Near Lewistown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE NOV 15 '61	
		25b. REGISTRAR'S SIGNATURE Charles S. Frame	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12495

CERTIFICATE OF DEATH

12184

1. PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Middleburg

c. LENGTH OF STAY IN lb

10 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Brookfield Manor Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Emma Margaret

Ridgely

4. DATE
OF
DEATH
November

Month

Day

Year
1961

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

March 1, 1877

9. AGE (in years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

84 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Own Home

Ragersville, Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Rhinehart

Unknown

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

None

17. INFORMANT

Mrs. Florence Urfer, Route #4, New Phila., Ohio

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)INTERVAL BETWEEN
ONSET AND DEATH

24 hrs

Gastro - Intestinal Hemorrhage

IMMEDIATE CAUSE (b)

DUE TO
Conditions, if any, which
gave rise to immediate cause

(c)

DUE TO
(e), stating the underlying
cause last.

2 yrs

(c)

Carcinoma of Pancreas

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY
PERFORMED?YES NO

Fx of Syst-hip - Cerebro-Vascular Hemorrhage

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 11, 1960, to 11/1/61, that (I) (we) last

saw the deceased alive on Oct. 28, 1961, and that death occurred at 9 A.M. from the causes and on the date stated above.

22a. SIGNATURE

E. Ambler Thompson

22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

E. Ambler Thompson

23a. BURIAL, CREMATION, REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

Burial Nov. 11, 1961 Harbaugh's Cemetery

24. FUNERAL DIRECTOR'S SIGNATURE

25e. REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

John M. Stiles
C.O. Fuss & Son

ADDRESS

NOV 13 '61

DATE

Arthur S. Traas



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12496

12485

1. PLACE OF DEATH

a. COUNTY

Carroll

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Westminster (Rural)

c. LENGTH OF STAY IN 1b

5 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Carroll County General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

0184

R

5. SEX

Female

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

Jesse C. Robertson

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war and dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

156-1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Carcinoma - liver

INTERVAL BETWEEN
ONSET AND DEATH

7 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY
Hour a.m. 20d. INJURY OCCURRED
White
at work at work p.m. 19
Not White
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from August 1961 to November 21, 1961, that (I) (we) last
saw the deceased alive on November 20, 1961, and that death occurred at 4:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Clarence E. McWilliams

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

CLARENCE E. McWILLIAMS

22d. ADDRESS

11904 Leisterstown Rd, Leisterstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

11/24/61

23c. NAME OF CEMETERY OR CREMATORI

Medium Branch Cemetery, Rural

23d. LOCATION (City, town or county)

, (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

J. E. Myers, Jr., Westminster, Md.

25a. REC'D. BY REGISTRAR

NOV 27 '61

25b. REGISTRAR'S SIGNATURE

John S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1249

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 1249

12186

1. PLACE OF DEATH

a. COUNTY

Carroll Co.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Westminster RT 2

c. LENGTH OF STAY IN 1b

60 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Union Mills

Middle

1. PLACE OF DEATH
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

b. COUNTY

Maryland Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

Rural Westminster RT #2

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECESSED
(Type or print)

WILLIAM EDWIN SCHAEFFER

4. SEX

5. COLOR OR RACE

Male

White

6. MARRIED
WIDOWED DIVORCED

7. NEVER MARRIED

8. DATE OF BIRTH

9. DATE
OF
DEATH

Last

10. AGE (In years
last birthday)

11. IF UNDER 1 YEAR
Months Days Hours Min.

12. IF UNDER 24 HRS.

13. CITIZEN OF WHAT COUNTRY

14. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH

19. WAS DECEASED EVER IN U.S. ARMED FORCES

(Yes, no, or unknown)

(If yes, give rank and date of service)

20. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

21. DECEASED HOW INJURY OCCURRED

22. PLACE OF INJURY

23. TIME OF INJURY

Month, Day, Year

24. INJURY OCCURRED

25. PLACE OF INJURY

(Home, farm,

factory, street, office bldg., etc.)

26. (City or town)

(County)

(State)

27. DEATH RESULTED FROM

28. ACTUAL
SIGNATURE

29. EXAMINER'S
NAME (Type)

30. BURIAL, CREMATION
REMOVAL (Specify)

31. DATE THEREOF

32. NAME OF CEMETERY OR CREMATORI

33. ADDRESS

34. REC'D BY REGISTRAR

35. REGISTRAR'S SIGNATURE

36. DATE

37. DATE SIGNED

38. ADDRESS (Street, city, town, or county)

39. LOCATION (City, town, or county)

(State)

40. DATE

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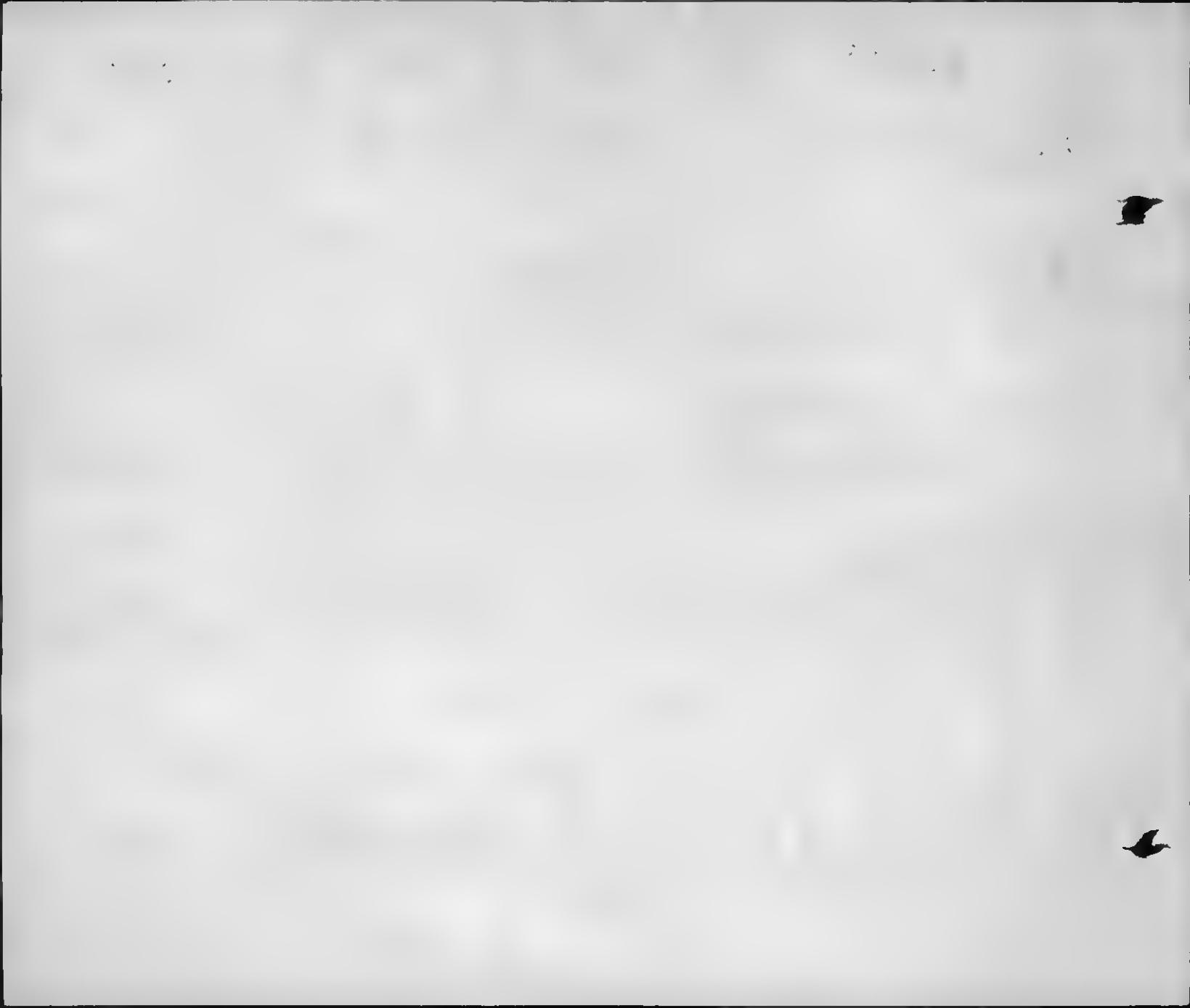
269. DATE

270. DATE

271. DATE

272. DATE

273. DATE



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12187

1. PLACE OF DEATH
a. COUNTY

Carroll

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural, Westminster

c. LENGTH OF STAY IN 16

MARYLAND

10 Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Westminster, Md. R. D. 2

3. NAME OF
DECEASED
(Type or print)

Chester

First

Middle

L.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farm

8. DATE OF BIRTH

11/28/1882

9. AGE (In years) IF UNDER 1 YEAR

78 yrs.

Months

Days

Hours

Min.

11. BIRTHPLACE (State or foreign country)

Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Noah Selby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO.

163-30-6649 Mrs. Beryl Hahn, Westminster, Md. R. D. 2

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

422.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Arterio Sclerotic Cardiac Vascular disease

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

2Dd. INJURY OCCURRED
While at work Not While at work

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

Carroll 11/27/61

DATE SIGNED

22a. BURIAL, CREMATION, OR REMOVAL (Specify)

Burial 11/29/61

22c. NAME OF CEMETERY OR CREMATORY

Mt. Carmel Cemetery

22d. LOCATION (City, town, or county)

Littlestown, Adams Co., Pa.

(State)

23. FUNERAL DIRECTOR

Richard A. Little

ADDRESS

Littlestown, Pa.

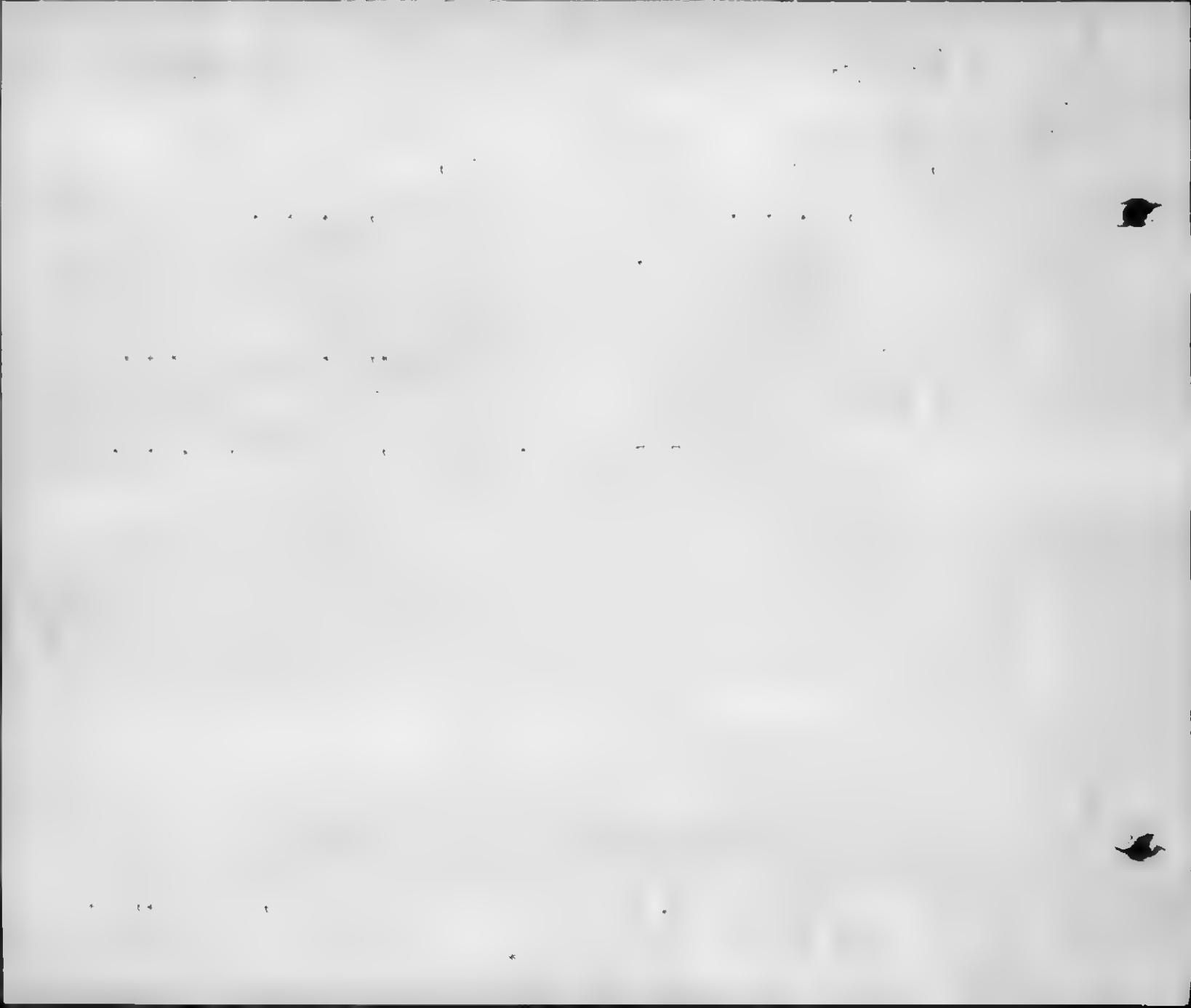
24a. REC'D BY REG STRR

NOV 29 '61

DATE

24b. REGISTRAR'S SIGNATURE

Richard A. Little



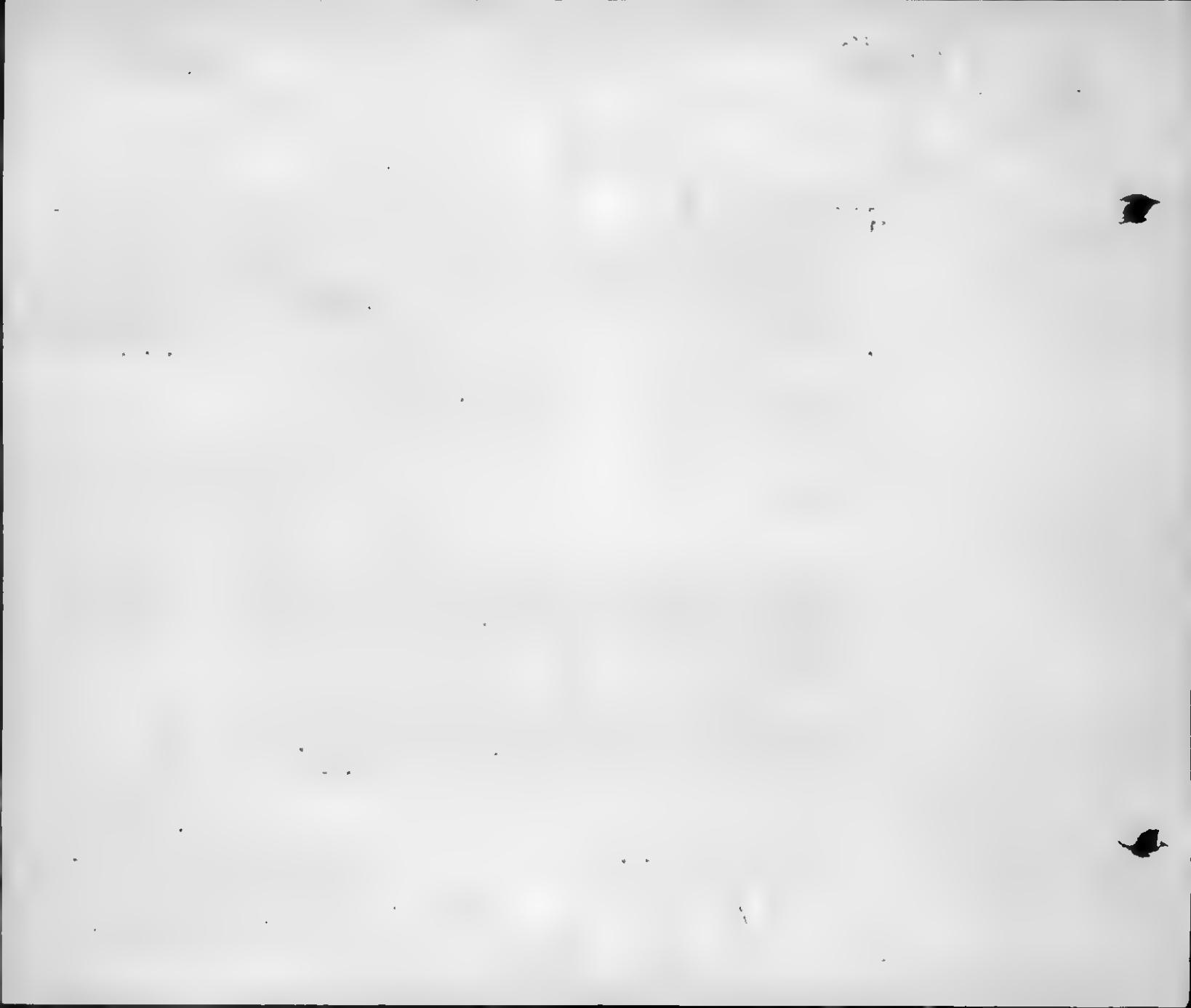
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12499		Item 1c, Film 0302-12499/61 ink		12188	
<p>1. PLACE OF DEATH a. COUNTY Carroll</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville</p> <p>c. LENGTH OF STAY IN 1b 8 yrs. 2 mos</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)</p> <p>a. STATE Maryland</p> <p>b. COUNTY Montgomery</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring</p>			
<p>3. NAME OF DECEASED (Type or print) Edward</p> <p>4. SEX Male</p> <p>5. COLOR OR RACE White</p>		<p>6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>7. WIDOWED <input type="checkbox"/></p> <p>8. DIVORCED <input type="checkbox"/></p>		<p>9. DATE OF BIRTH September 27, 1895</p> <p>10. AGE (In years last birthday) 66 yrs.</p> <p>11. BIRTHPLACE (County & State, or foreign country) New York</p>	
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>					
<p>13. FATHER'S NAME John William Shine</p>		<p>14. MOTHER'S MAIDEN NAME G. Martin</p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <input type="checkbox"/> (If yes give year or date of service) No</p>		<p>16. SOCIAL SECURITY NO. - - - - -</p>		<p>17. INFORMANT Springfield Hospital Records</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. Coronary thrombosis</p> <p>DUE TO (b) Acute Myocardial Infarction</p> <p>DUE TO (c) Manic depressive psychosis, hypomanic type.</p>				<p>INTERVAL BETWEEN ONSET AND DEATH Days</p> <p>Years</p> <p>Days</p>	
<p>19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>					
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.</p> <p>20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Nov. 25, 1961</p>	
				<p>(County) Montgomery (State) Md.</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1953 to Nov. 25, 1961, that (I) (we) last saw the deceased alive on Nov. 25, 1961, and that death occurred at 5:30 P.M. from the causes and on the date stated above.</p>					
<p>22e. SIGNATURE Agustin del Campo</p>		<p>22b. DATE SIGNED Nov. 25, 1961</p>			
<p>22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.</p>		<p>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov. 28, 1961 Mt. Olivet Cemetery</p>		<p>23b. DATE THEREOF Nov. 28, 1961</p>		<p>23d. LOCATION (City, town or county) Washington, D.C.</p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE J. F. Costello, 1722 N. Cap. W. Wash. D.C.</p>		<p>ADDRESS 1722 N. Cap. W. Wash. D.C.</p>		<p>25a. REC'D BY REGISTRAR NOV 27 '61</p>	
				<p>25b. REGISTRAR'S SIGNATURE Arthur S. Kraus</p>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12500

CERTIFICATE OF DEATH

Reg. Dist. No. 189

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission] a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Tyrone		c. LENGTH OF STAY IN 1b Few Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Union Bridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Route 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charley		First	Middle	Last	4. DATE OF DEATH November 18 1961	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas H. Smith			14. MOTHER'S MAIDEN NAME Minnie Hatfield					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. No 217-36-4747		17. INFORMANT Mrs. Charley D. Smith, Union Bridge, Rl, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO <i>Coronary occlusion</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Coronary artery disease</i> ONSET AND DEATH "year. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>James T. Marsh</i> M.D. <i>11/28/61</i> PHYSICIAN'S NAME (Type) <i>JAMES T. MARSH</i> <i>Westminster</i> <i>Md.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Church of God Cemetery		22d. LOCATION (City, town, or county) Uniontown, Carroll, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Skiles</i> C.O. Fuss & Son		ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR OV 21 '61		24b. REGISTRAR'S SIGNATURE <i>C. J. Fuss</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12501

12490

CERTIFICATE OF DEATH

1. PLACE OF DEATH

e. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Henryton

c. LENGTH OF STAY IN lb

363 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Henryton State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

Negro

WIDOWED DIVORCED 9. AGE (In years)
last birthday10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (County & State, or foreign country)

13. CITIZEN OF WHAT COUNTRY

Laborer

Unknown

Smith

November 21 1961

Months

Days

Hours

Min.

13. FATHER'S NAME

James E. Smith

Bristol, Maryland

USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or peace of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

218-03-5313

Mary Elizabeth Dorsey

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Meningitis, Cerebro-vascular accident

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first.

DUE TO

(b)

Far advanced bilateral cavitary pulmonary tbc.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that (I) (this hospital) attended the deceased from Nov. 23 5:15 p.m. to Nov. 21, 1961, that (I) (we) last
saw the deceased alive on Nov. 21, 1961, and that death occurred at _____, from the causes and on the date stated above.

22e. SIGNATURE

Edgars M. Maculans

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
Nov. 21, 196122c. PHYSICIAN'S
NAME (Type)

Edgars M. Maculans, M. D.

22d. ADDRESS

Henryton, Maryland

23e. BURIAL/CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

11-26-61

Noses

Bristol, Md.

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

P. G. Surrill Prince Frederick, Md.

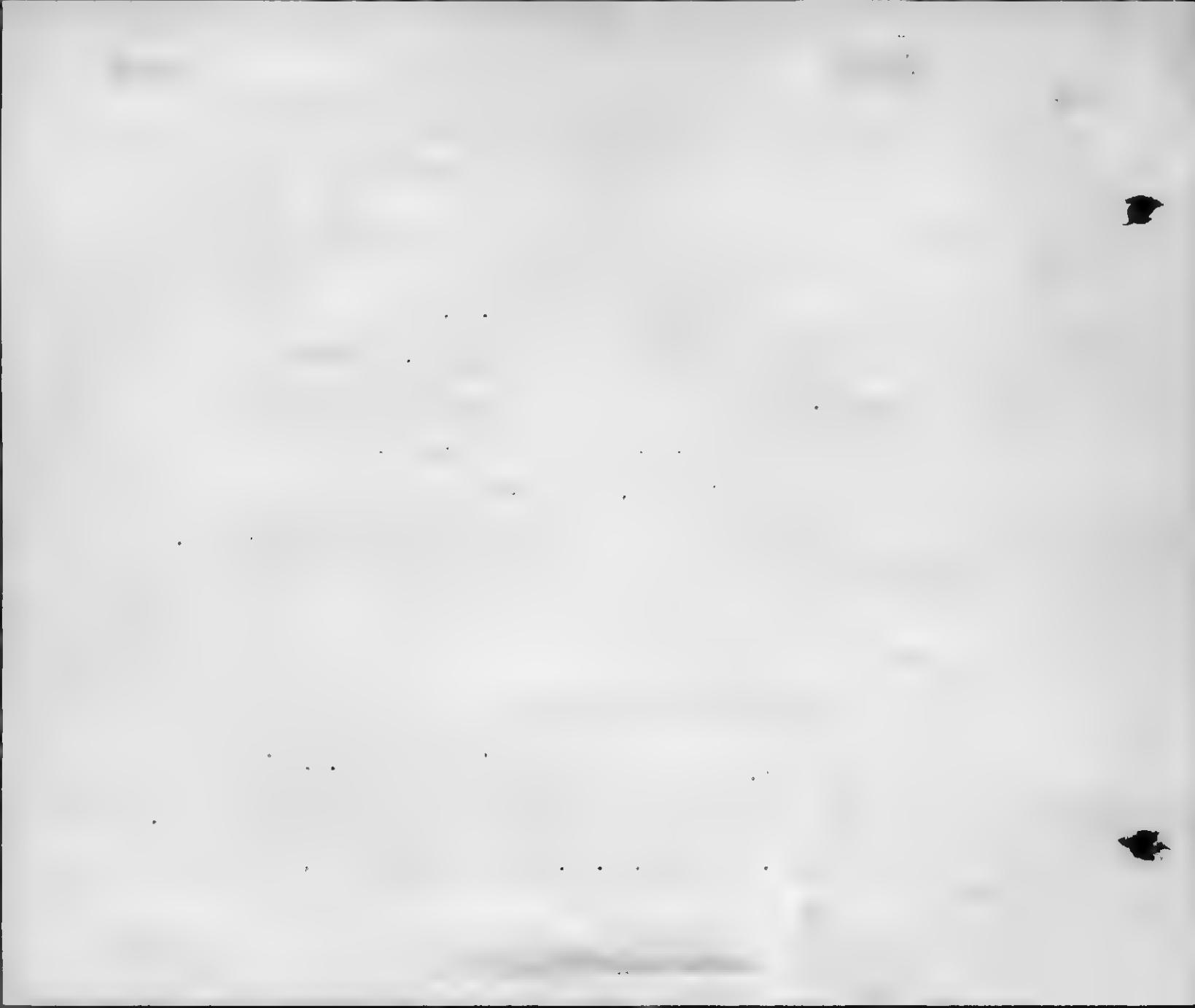
ADDRESS

25e. REC'D BY REGISTRAR

NOV 28 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12502

CERTIFICATE OF DEATH

12191

1. PLACE OF DEATH *Carroll County*

e. COUNTY

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN lb

30 yrs

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

M dd.e

Last

4. DATE
OF
DEATH

Month Nov 12

Day 19

Year 61

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Oct 1-1866

9. AGE (in years
last birthday)

95 yrs.

10. IF UNDER 1 YEAR

Months 0

11. IF UNDER 24 HRS.

Days 0

Hours 0

Min. 0

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

13. FATHER'S NAME

Silas Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO

16. SOCIAL SECURITY NO. 17. INFORMANT

204-01-3528- Eule Spahr

Hampstead

18. CAUSE OF DEATH (Enter only one cause of death for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

332X DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last. (b)

DUE TO

(c)

Cerebral Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

1 week

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from *Nov. 7* 1961 to *Nov. 11* 1961, that (I) (we) last
saw the deceased alive on *Nov. 11* 1961, and that death occurred at *4a.m.* from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

M.C. Porterfield, M.D.

ATTENDING
PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

Hampstead, Md.

22b. DATE
SIGNED
11-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 11-15-61

23b. DATE THEREOF

Wesley Methodist

23d. LOCATION (City, town or county)

Carroll Co

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Tipton-Ellis - Hampstead Md

ADDRESS

25a. REC'D BY REGISTRAR
NOV 16 1961

DATE

25b. REGISTRAR'S SIGNATURE
Arthur S. Kline

TO HOSPITALIZING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12503

CERTIFICATE OF DEATH

12492

1. PLACE OF DEATH

a. COUNTY

Maurand

b. CITY OR TOWN (if outside corporate limits, give RURAL and give nearest town)

Maurand

c. LENGTH OF STAY IN 1b

MARYLAND

5-7-61

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Fairview Conv. Home

3. NAME OF DECEASED

First

Middle

Last

DATE

OF

DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

WIDOWED

D.VORCED

B. DATE OF BIRTH

March 25-1876

85

Yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. FATHER'S NAME

12. CITIZEN OF WHAT COUNTRY

13. MOTHER'S MAIDEN NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes, give year or dates of service)

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Thrombosis

DUE TO

Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first.

DUE TO

(b) Cerebral Arterio-Sclerosis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

While at work

p.m.

Not While at work

20d. INJURY OCCURRED

at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

at work

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from March 1861 to Nov. 4, 1961, that (I) (we) last

saw the deceased alive on Nov. 3, 1961, and that death occurred at a.m. from the causes and on the date stated above.

22e. SIGNATURE

McPorterfield

22c. PHYSICIAN'S NAME (Type)

M.D.

M.C. Porterfield, M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

22b. DATE SIGNED

Hampstead, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

Burial

Nov. 6, 1961

23c. NAME OF CEMETERY OR CEMATORIAL

ADDRESS

Fairview

Hampstead, Md.

23d. LOCATION (City, town or county)

(State)

Burial to 7626

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Lipton & Elkin

Hampstead, Md.

25a. REC'D BY REGISTRAR

DATE

Nov. 8, 1961

1961

25b. REGISTRAR'S SIGNATURE

Signature

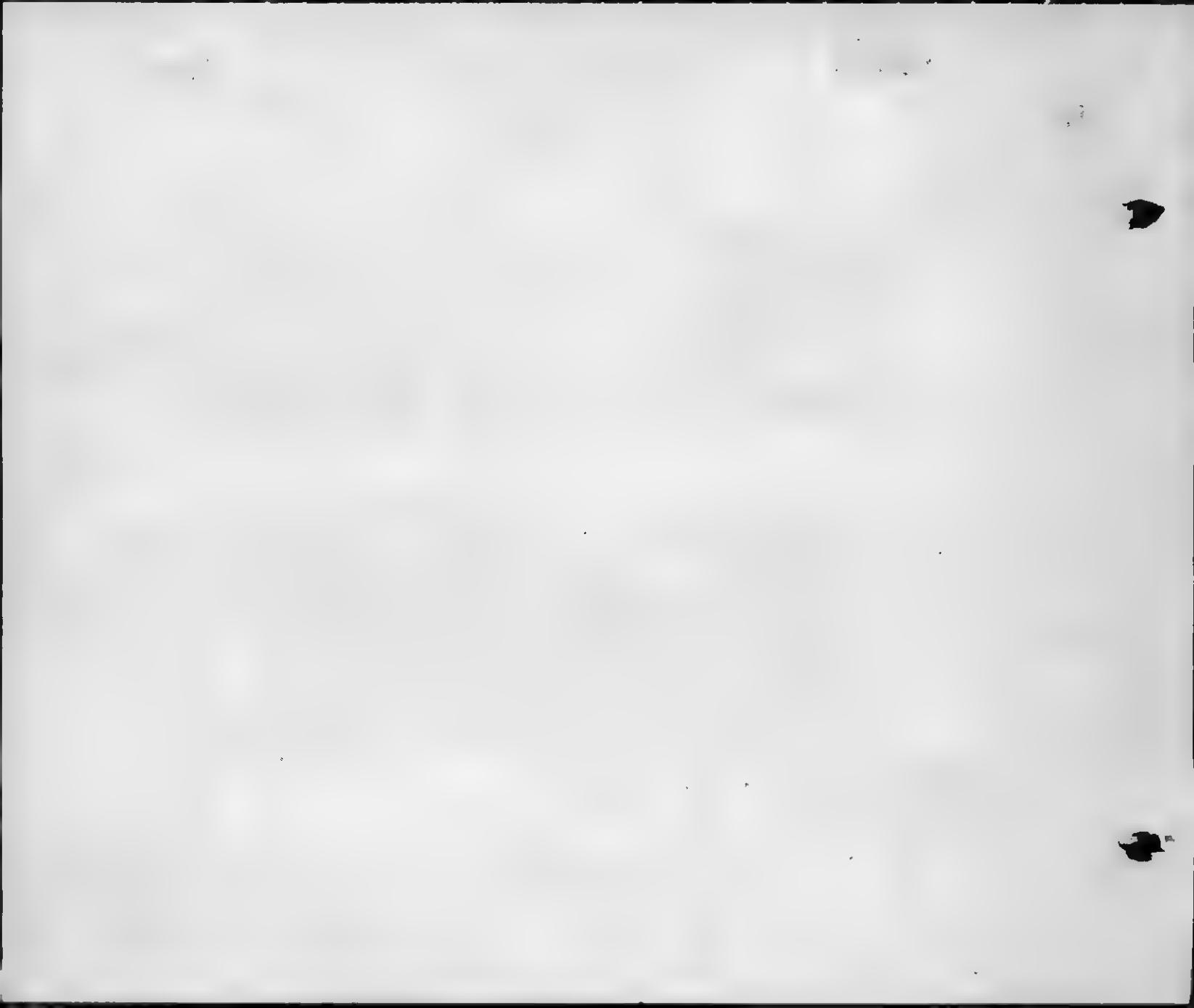
John S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60



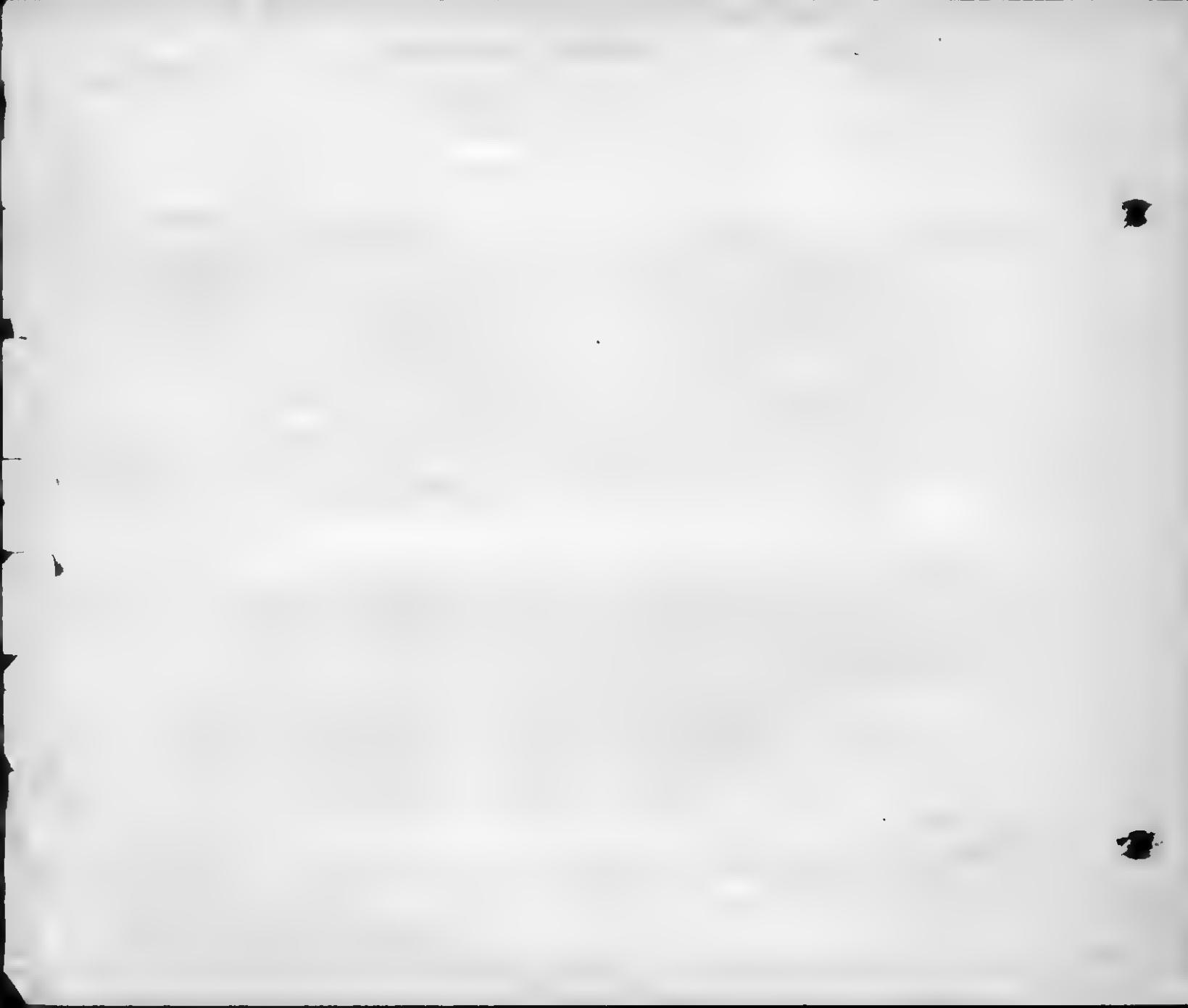
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12504

CERTIFICATE OF DEATH

Reg. Dist. No. 1234567

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>66</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 WARD AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE FRANCIS STEM</u>		First <u>CLARENCE</u>	Middle <u>FRANCIS</u>
4. DATE OF DEATH <u>NOVEMBER 15 1961</u>		Month <u>NOVEMBER</u>	Day Year <u>15 1961</u>
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <u>JAN 25, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS & ELECTRIC CO</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>JESSE FRANCIS STEM</u>		14. MOTHER'S MAIDEN NAME <u>MARY ORNDORFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-4424</u>	17. INFORMANT Address <u>WIFE - MRS. SARAH STEM 15 WARD AVE, WESTMINSTER</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA RIGHT LUNG</u>		INTERVAL BETWEEN/ ONSET AND DEATH <u>1 YEAR</u>	
DUE TO <u>165X</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <u>CEREBRAL THROMBOSIS WITH RT. HEMIPARESIS 18 MO S</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CEREBRAL THROMBOSIS WITH RT. HEMIPARESIS 18 MO S</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) <u>3 1/4 AM</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>19 RIDGE RD</u>	
21. I certify that I attended the deceased from <u>JUNE</u> , 1960, to <u>NOV. 15</u> , 1961, that I last saw the deceased alive on <u>NOV. 13</u> , 1961, and that death occurred at <u>3 1/4 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>19 RIDGE RD</u> DATE SIGNED <u>11/15/61</u>			
ACTUAL SIGNATURE <u>William J. Stewart, M.D.</u> PHYSICIAN'S NAME (Type) <u>WILLIAM J. STEWART</u> WESTMINSTER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/61</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>St. John's Cemetery</u>
22d. LOCATION (City, town, or county) <u>Westminster, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

12505

12191

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Carroll

b. CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town)

Henryton

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Henryton State Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Cora

Stevenson

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

Negro

WIDOWED DIVORCED

1-4-1887

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOC. SEC. NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank and date of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

334 X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

Unknown Cora Stevenson- Patient

Cerebrovascular Disease, Hemiplegia

Arteriosclerosis, Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

002X

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

2De. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. Who Not Who
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 7, 1961, to November 15, 1961, that (I) (we) last saw the deceased alive on Nov. 15, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Edgars M. Maculans

10:07AM

22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Dr. Edgars M. Maculans, M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

Nov. 15, 1961

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

11/18/61

23c. NAME OF CEMETERY OR CREMATORIAL

Arling

23d. LOCATION (City, town or county)

Baltimore

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Clyton Mainwright

ADDRESS

25e. REC'D BY REGISTRAR

NOV 20 '61

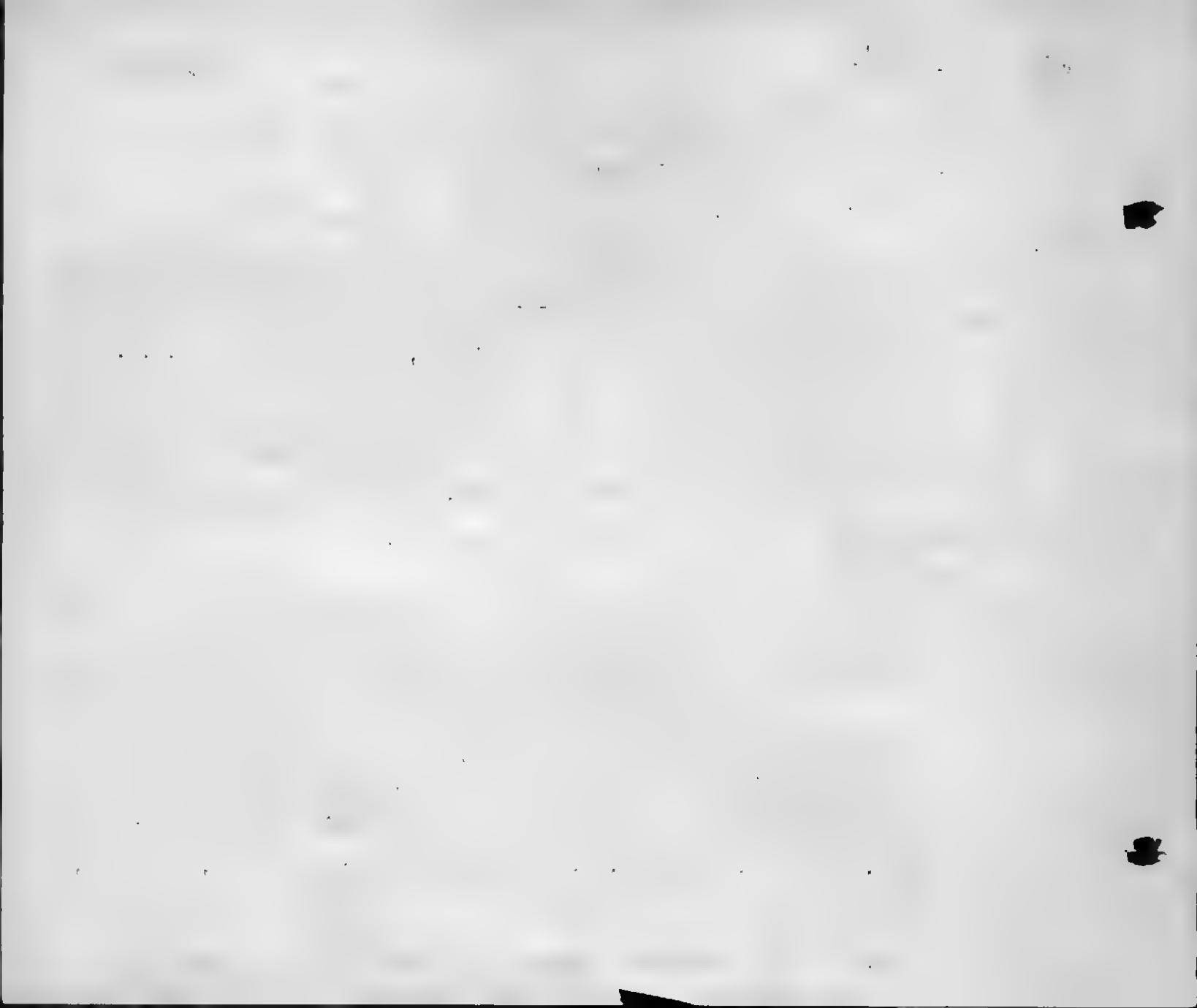
25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



FOR STATE
DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12506

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12495

1. PLACE OF DEATH

a. COUNTY

Carroll

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Westminster

MARYLAND

c. LENGTH OF STAY IN 1b

50 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

26 Colonial Ave.

First
Middle

3. NAME OF
DECEASED
(Type or print)

CHARLES DAVID WAGNER

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

July 4, 1902

59 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter and builder

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Harry Wagner

4. DATE
OF
DEATH

Last

Month

Day

Year

NOV 1

1961

IF UNDER 1 YEAR

Months

Days

Hours

Min.

12. CITIZEN OF WHAT COUNTRY?

Carroll Co. Md. U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unknown) (If yes, give record of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

218-03-1727

Eldon D. Wagner, Embalming R.D. 1

Address

INTERVAL BETWEEN
ONSET AND DEATH
Minutes

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

CARROLL 111/1/61
(State)

22e. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

Burial 11/3/61 Braggs Memorial Garden Embalming R.D. Md.

ADDRESS

24e. REC'D BY REGISTRAR

NOV 3 '61

24b. REGISTRAR'S SIGNATURE

Cuthbert S. Frame

VS. A15ME
5M 7/59

B70

23. FUNERAL DIRECTOR

J. E. Myers, Jr., Westminster, Md.

DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

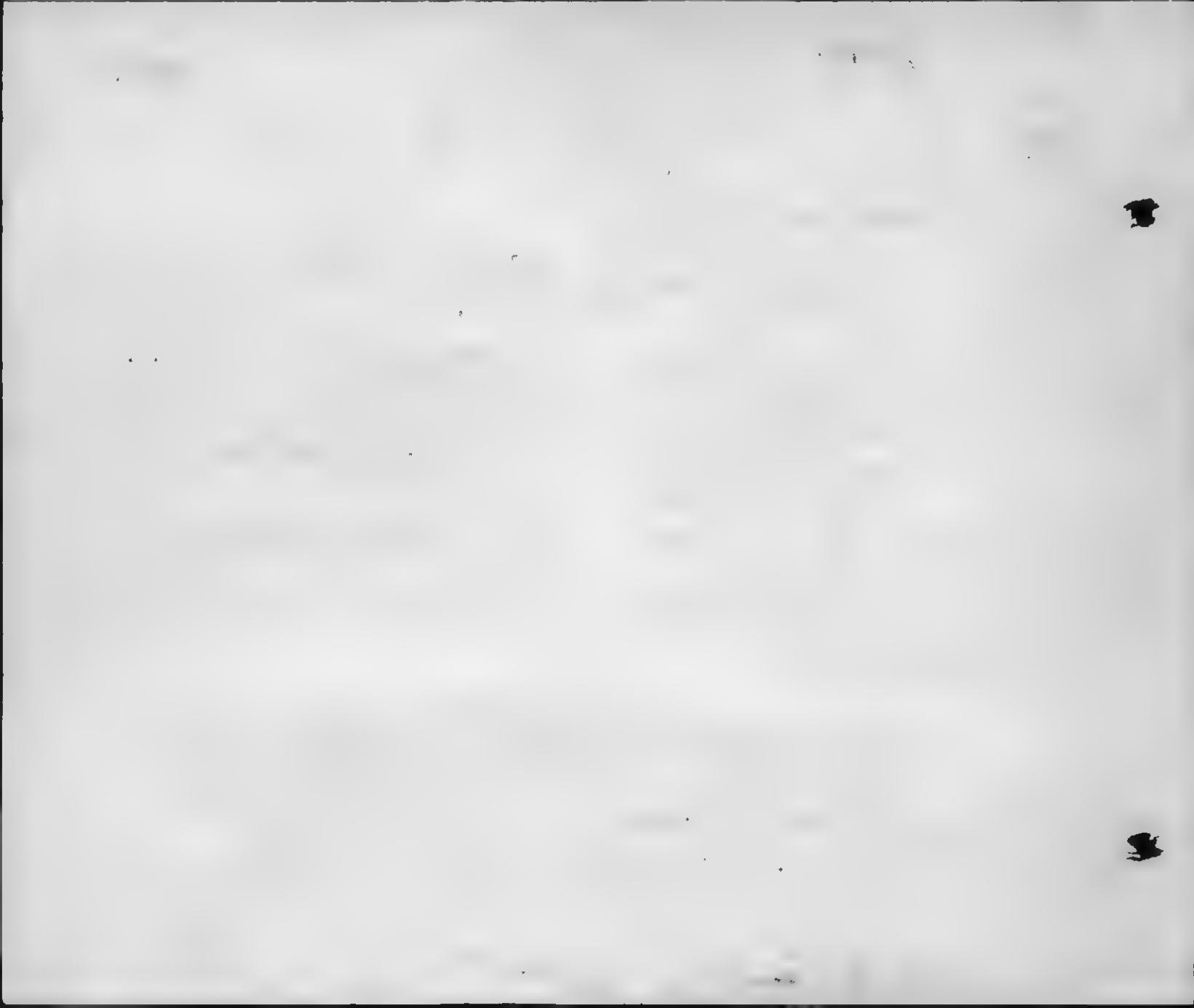
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely typed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

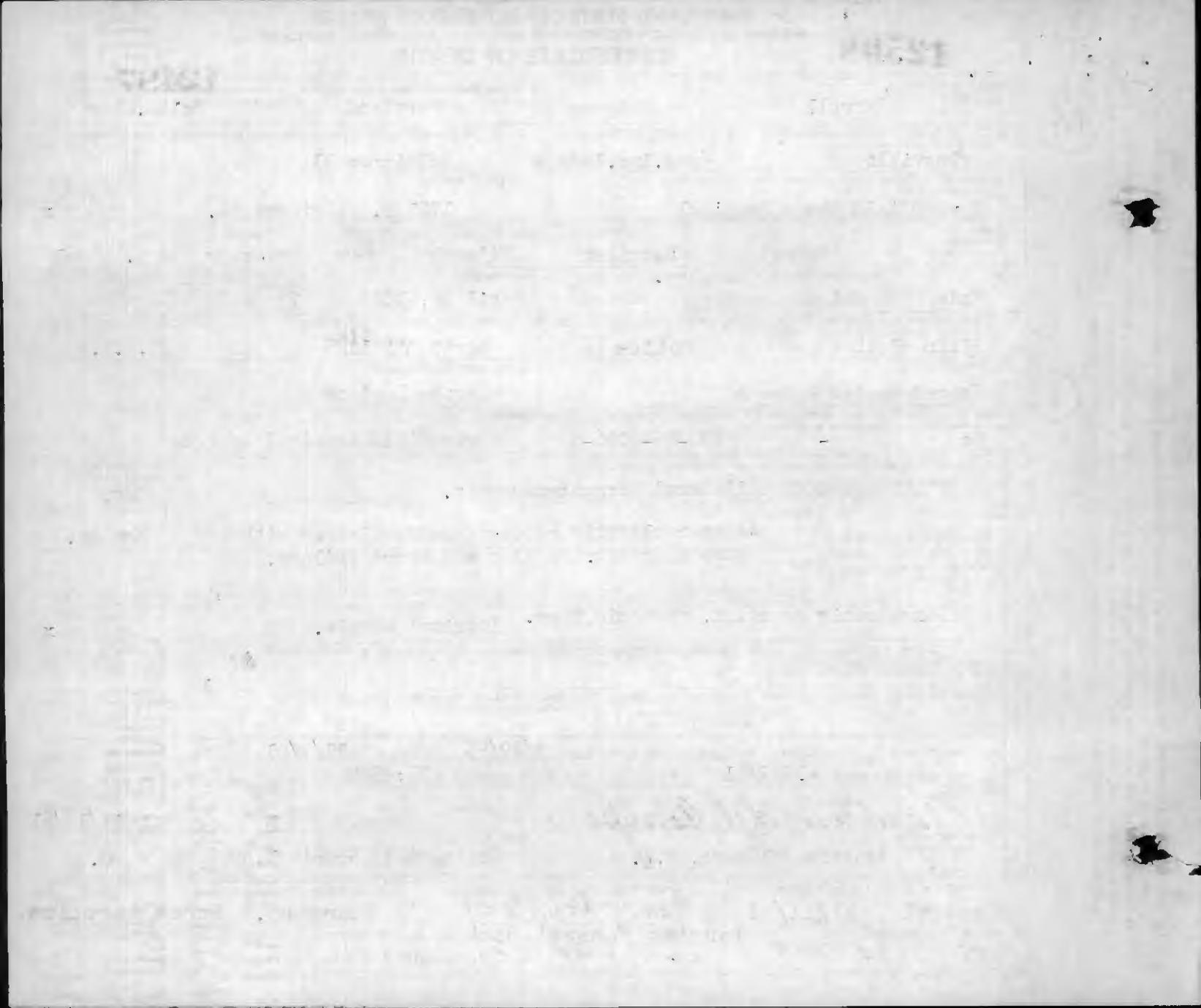
1		12507		12196		
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
Carroll		a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY 12196				
Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Catonsville				
Henryton State Hospital		d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year	
Mary				Walton	Nov 19 1961	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS.
Female		Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 21, 1917	44 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country)		12. CITIZEN OF WHAT COUNTRY
Housewife		Home		Alabama		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Arthur Toney		Lena King				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address
No		Unknown		Mary Walton, - Henryton State Hosp., Henryton		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Car Pulmonary				
DUE TO		Far advanced Bilateral Cavitary Pulmonary TB				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)				
DUE TO		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. CITY OR TOWN	(County)	(State)
19						
21. I certify that (I) (this hospital) attended the deceased from Mar 26, 1954 to Nov 19, 1961, that (I) (we) last saw the deceased alive on Nov 19, 1961, and that death occurred at 4:45 AM from the causes and on the date stated above.						
22a. SIGNATURE		Edgars M. Maculans		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS		
Edgars M. Maculans				Henryton State Hospital, Henryton, Md		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county)		(State)
Burial		Nov. 24, 1961	Oakdale Cemetery	Brighton Alabama		
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Herbert E. Gantner		3035 W. Roanoke	NOV 20 '61	Arthur S. Thomas		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be read by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12508		1216-1216									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Maryland b. COUNTY Balto. City						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6yrs.1mo.10days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1721 E. Baltimore St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Robert	Middle Harrison	Last Wilmoth	4. DATE OF DEATH November	Month 9	Day 1961	Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1888		9. AGE (In years from last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plain clothes man			10b. KIND OF BUSINESS OR INDUSTRY Police			11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jasper Newton Wilmoth					14. MOTHER'S MAIDEN NAME Martha Lusinda						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 230-05-9096-A			17. INFORMANT Springfield Hospital Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia. INTERVAL BETWEEN ONSET AND DEATH Days 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardiovascular disease with DUE TO auricular fibrillation and heart failure. Months. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type. Inguinal hernia. INTERVAL BETWEEN ONSET AND DEATH Days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9/29/55 19 to 11/9/61 19, that (I) (we) last saw the deceased alive on 11/9/61 19, and that death occurred at 11:35PM from the causes and on the date stated above.											
22a. SIGNATURE <i>Agustin del Campo</i>					M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.					22b. DATE SIGNED 11/10/61						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/11/61		23c. NAME OF CEMETERY OR CREMATORIAL Family Cemetery			23d. LOCATION (City, town, or county) Thurmond, North Carolina			(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Horning</i>		Tarr ADDRESS Funeral Home 1721 E. Baltimore St.		25a. REC'D BY REGISTRAR DATE NOV 14 '61			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12509

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN lb

17 yrs. 9 mos. 15 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Springfield State Hospital

3. NAME OF
DECEASED
(Type or print)First Middle
Dorey R.Last Month Day Year
Zepp November 3, 19614. DATE
OF
DEATH

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

June 23, 1874

9. AGE (In years
last birthday)

87 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Huckster

10b. KIND OF BUSINESS OR INDUSTRY

Garlic vegetables

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Zepp

14. MOTHER'S MAIDEN NAME

Sarah A. Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or dates of service]

No

16. SOCIAL SECURITY NO.

- - -

17. INFORMANT

Address

Springfield Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Bronchopneumonia

INTERVAL BETWEEN
ONSET AND DEATH

Days

49 1/2

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Manic depressive psychosis, manic type. Squamous cell carcinoma of
skin of patella. Diabetes Mellitus.19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 18, 1944 to November 3 1961, that (I) (we) last saw the deceased alive on 11/3/61, and that death occurred at 8:15AM from the causes and on the date stated above.

22a. SIGNATURE

Agustin del Campo

M.D.

22b. DATE
SIGNED

11/3/61

22c. PHYSICIAN'S
NAME (Type)

Agustin del Campo, M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

11-9-61

23c. NAME OF CEMETERY OR CREMATORIAL

Trick Bethel

23d. LOCATION (City, town or county)

New Windsor, Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE

Arthur H. Height Sykesville, Md.

ADDRESS

25a. REC'D. BY REGISTRAR

NOV 10 '61

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

20151

20151

M